SOUTH CENTRAL REGION
EMS & TRAUMA CARE
BIENNIAL PLAN

2003 - 2005

Rev. 09/18/2003

TABLE OF CONTENTS

I. AUTHORITY

A. RCW 70.168.015(7) "Emergency medical services and trauma care system plan" means

a state-wide plan that identifies state-wide emergency medical services and trauma care objectives and priorities and identifies equipment, facility, personnel, training and other needs required to create and maintain a state-wide emergency medical services and trauma care system. The plan also includes a plan of implementation that identifies the state, regional and local activities that will create, operate, maintain and enhance the system. The plan is formulated by incorporating the regional emergency medical services and trauma care plans required under this chapter..."

RCW 70.168.120 and WAC 246-976-960 provides the authority for and direction to regional and local EMS & trauma care councils. The composition of the councils are outlined as well as their duties such as developing and implementing the regional trauma system, identify the need for and recommending distribution and level of care of EMS agencies and distribution and levels of trauma services. Regional Councils are to seek input from local EMS & Trauma Care Councils, Medical Program Directors, and communication centers for development of the trauma plan and Regional Patient Care Procedures.

B. MISSION STATEMENT

The Department of Health Office of EMS & Trauma developed the following Mission Statement for the EMS and Trauma Care System:

> ***To establish, promote, and maintain a system of effective emergency medical and trauma care services. Such a system provides timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury, and recognizes the changing methods and environment for providing optimal emergency care throughout the State of Washington.***

Trauma is the number one killer of Americans between the ages of one and thirty-four. Virtually all trauma deaths are considered avoidable. National statistics have proven that trauma deaths are greatly reduced when an organized trauma system is in place. A successful trauma system is more than a vision and commitment from Emergency Medical Service (EMS) agencies and health facilities acting as trauma services, it is a commitment from society as a whole. Washington State embarked on just such a commitment when the State Legislators passed the 1990 Trauma Bill. The Trauma Bill states that it is in the best interest of the public to establish an efficient and well-coordinated statewide EMS and trauma care system.

The South Central Region EMS & Trauma Care Council wholeheartedly endorses this mission statement and adds this additional regional mission - to minimize the human suffering and costs associated with preventable trauma related mortality and morbidity. To accomplish these missions the Regional Council has developed an EMS and Trauma Care System plan that recognizes already established EMS agencies and health care facilities.

The Regional Council's goal for EMS was to establish a tiered response of first responders, basic life support (BLS) ambulances and advanced life support (ALS) ambulances with working rendezvous agreements. Through assessment of needs and resources, the Regional Council recommends minimum and maximum numbers for trauma verified EMS services.

Over the years, EMS agencies have been established in areas where need was identified. EMS agencies have increased their trauma verification levels to meet additional needs identified in the trauma plan.

The Regional Council also recommends levels and locations for designated trauma services throughout the Region. Although the levels of trauma service designation have not been met in all instances, all health care facilities identified in the Trauma Plan are participating in the Trauma System. Truly, some trauma services have assumed their roles in unique and precedent setting ways.

II. INTRODUCTION

A. Summary of Proposed Changes:

The South Central Region has an established procedure of Regional Guidelines established in 1997 that provide the opportunity for local EMS and Trauma Care Councils, MPDs, designated trauma services, EMS agencies and emergency dispatch centers to provide input and update to the Trauma Plan and Patient Care Procedures (PCP)

The Regional Council has established Regional Guideline #5 Review and Revision of Current Patient Care Procedures and Regional Guideline #6 Development of New Patient Care Procedures to provide direction and input of local EMS & Trauma Care Councils and Medical Program Directors in the review of current PCPs and development of new PCPs.

Following that review process, it is determined that there are no recommended changes to the following components:

- Minimum and maximum numbers of recommended trauma verified EMS services. Changes to "actual numbers" reflect services that have been established or moved into higher levels of EMS service per established Trauma Plan recommendations, and within the existing min/max limits

- Minimum and maximum numbers and levels of designated trauma services, pediatric designated trauma services, and designated trauma rehabilitation services.

  Because, health care facilities have designated at levels lower than Regional Council recommendations, minimum and maximum trauma service numbers have become confused over the years. The Regional Council continues to encourage trauma services to increase designation levels to the recommendations in this Trauma Plan.

- There are no higher than state minimum standards proposed by the South Central Region EMS & Trauma Care Council.

Changes have been made to Patient Care Procedure #3, Triage and Transport, and Patient Care Procedure #8, Diversion, to expanded and further clarify specific patient conditions that would over-ride the decision to divert. County Operating Procedures in several counties are being revised to meet the need for COPs for Emergency Medical Helicopter procedures now that Northwest MedStar has established a helicopter within the South Central Region. Those COPs will be forwarded to DOH as they are submitted to the Regional Council.

B. Executive Summary

The South Central EMS and Trauma Care System Plan addresses the continuum of EMS and trauma care from access to 911, through prehospital and hospital components, and system evaluation. The regional system has evolved over several decades. Many people involved in EMS and trauma care have been and continue to be involved in the regional system. There have been many system improvements during the years. However there are unmet needs, old and new, that the South Central EMS and Trauma Care System plan identifies and for which resources are needed. Each section of the plan identifies specific needs, sets goals, and proposes actions to address the needs during the biennium.

Issue/Need/Weakness Statement
Common issues in many FY 02-03 regional plans:

- Provider recruitment/retention, especially volunteers
- Rural/Geographic issues, long transports, weather, and communications
- Communication dead spots/difficulty during disasters
- EMD issues, recruitment/retention, consistent training, and preventing burnout
- Tourist impact on all regions including times of year
- Funding low for all levels of the system

Injury Prevention - Injury prevention and public education is the one true cure for the epidemic of trauma. The Region supports this important element through agreements and contracts for grants with the SAFE KIDS Coalitions within the Region. Injury Prevention activities include such projects as child car seat installation programs and head injury prevention activities coupled with bike and sports helmet fitting and distribution programs.

Prehospital Communication -In the South Central Region, some elements of prehospital system EMS work well and others still require improvement. Enhanced 9-1-1 emergency telephone access is available Region wide. The Regional Council encourages standardized emergency medical dispatcher (EMD) training courses that provide locally based EMD training. Dispatch centers are experiencing a high turnover of staff that results in an ongoing need for local dispatcher training in EMD. VHF HEAR radio is the Region's primary communication link between EMS and trauma services. Cell phones and 800 MHz radios are alternate communication methods within specific areas of the region. Areas of "black holes" and difficult radio communications continue to be identified within the plan. Additionally, there are communication incompatibilities between public and private EMS and other agencies. This requires a statewide solution. The Regional Council is working with the state communication system to explore new directions and possibilities for EMS & trauma system communications. Resolving ambulance to hospital communication issue is critical.

Medical Direction - The South Central Region has five Medical Program Directors, who provide medical direction of prehospital providers under RCW 18.71.212 through 18.71.215 and WAC 246-976-920. They have developed county protocols giving specifics of medical care and direction to EMS providers. The local EMS & Trauma Care Councils in collaborations with the County MPDs have developed County Operating Procedures to add specificity to how Regional Patient Care Procedures will be implemented in each county. The MPDs participate in local trauma system planning but have not moved to the Regional Council level of participation. The Regional Council continues to encourage MPD involvement by sending them information on Regional Council meetings and subcommittee meetings.

Prehospital Services - Another challenge for the South Central Region is long EMS response and transport times due to our large rural areas. The Region has developed an organized three-tiered EMS response system. The "system" is made up of First Responder aid services, which are backed by BLS ambulances, which rendezvous with ALS ambulances. The Regional Council identified and established First Responder aid services in several rural areas where the need was identified. The Regional Council also encourages

and promotes trauma verification of all EMS agencies. Yet another common need identified by the South Central Region is recruitment and retention of EMS volunteers. One rural BLS ambulance in Franklin County #2 area has dropped its trauma verification due to lack of volunteers to man the ambulance. The Regional Council has facilitated several EMT courses close to this rural area in an attempt to recruit additional EMS responders. EMS continuing medical education (CME) and ongoing trauma education programs (OTEP) have been established through established Regional contracts with the five local EMS and trauma care councils. Initial EMS training is provided frequently throughout the Region.

Increased tourist activities greatly impact all of our counties but especially our two most rural counties, Columbia and Kittitas. Recreational activities within in these two counties can almost double the actual population of the area, putting a great strain on the limited volunteer EMS systems. The economics of the counties cannot support the increased need for EMS services during these peak recreational times.

Columbia County has a volunteer BLS ambulance. The Regional Council has targeted this County for an increase to ALS service but the lack of County finances cannot support this increase.

In addition, Kittitas County has a major interstate highway, I-90, that passes through the breath of the county. Large numbers of passenger cars and truck traffic pass through the County each day with resulting crashes that increases the need for EMS care. Once again the County does not have the tax base to fund an increase in EMS services.

National statistics show that rapid transport of trauma patients to trauma centers significantly increases survival rates. National trauma system studies advocate rapid emergency transport by EMS helicopter. The Region did not have emergency medical helicopter service until January of 2003. Regional data will provide information on the impact of rapid trauma and medical transport on the EMS & Trauma system. A Regional need is to keep this service in place to insure rapid transport and to have enough calls to keep it in business.

The Region does have fixed wing medical air transport services available for inter-facility transfers between trauma services through three services. The U.S. Army MAST helicopter located on the Yakima Training Center also is available for wilderness rescue as needed.

Patient Care Procedures - Twelve Regional Patient Care Procedures have been developed to provide specific directions for how the trauma system should function. PCP #3, Triage and Transport and PCP #8, Diversion have been expanded. The local EMS & Trauma Care Councils have developed County Operating Procedures that provide even more specific local direction. In addition, the Regional Council has established Regional Guidelines that provides an established system and internal structure to assure uniformity for input and update of the trauma plan and Regional PCPs. PCPs are reviewed at least every two years and more often as needed.

Designated Trauma Services – Regional trauma services range from modern medical center in the urban/suburban areas to small rural hospitals. All Regional health care

services have been trauma designated, however several have not designated at the levels recommended by the Regional Council. The Regional Council has identified the need to continue to work with the trauma services toward increasing their designation levels in order to provide optimal geographical distribution of appropriate levels of care for trauma patients across the region.

Data Collection and Submission - The Regional Council recognizes that trauma registry data is the key to continued development and implementation of a trauma system. Designated trauma services are now collecting and submitting both EMS and trauma service Trauma Registry data. The Regional Council will continue to promote and encourage continued submission of Trauma Registry data. There is a need to identify the most effective role for the Regional Council to play in transitioning prehospital data collection to the hospitals. Making the process easy and monitoring its success are needed to ensure that comprehensive data is available for system evaluation.

EMS & Trauma System Evaluation - The Regional trauma services provide the regional Continuous Quality Improvement (CQI) Committee program. The CQI Committee meets quarterly to analyze trends, review Trauma Registry statistics, and identify Regional trauma system issues. Comprehensive data collection is needed within the South Central Region to enable the system CQI committee to analyze the entire system and provide information the Regional Council can use to improve the regional system.

The Regional Council has long accepted its leadership role for development of the trauma system. The Regional Council will continue to advocate and promote the continuing evolution of the Regional and Statewide trauma system.

SYSTEM OPERATION COMPONENTS

III. INJURY PREVENTION/PUBLIC EDUCATION

A. Regional IPPE Programs
Demographics

Comparison of State and SCR Injury Related Deaths
From Washington State Vital Statistics 2001

	WA State 1997-2001	South Central Region 1997-2001
# Injury Deaths	9,781	934
MVC Deaths	2,734	342
Fall Deaths	1,892	144
Poisoning	1,865	127
Drowning Deaths	544	48
Pedestrian	78	30
Other	2,668	243
Suicide Deaths	3,684	293
Homicide Deaths	1,075	112

Injury Related Deaths by Counties

Injury Deaths	Benton		Columbia		Kittitas		Franklin		Walla Walla		Yakima	
	1999	2000	1999	2000	1999	2000	1999	2000	1999	2000	1999	2000
Totals	56	71	4	4	9	9	23	21	31	26	152	124
MVC	15	19	1	4	4	3	8	11	2	3	25	35
Falls	6	11	0	0	1	3	0	1	3	7	8	11
Drowning	1	4	0	0	0	1	1	1	2	2	6	2
Burns	0	3	0	0	0	0	0	0	1	0	4	1
Other	13	19	2	0	1	1	10	2	7	5	67	33
Suicide	19	14	1	0	2	1	3	2	10	9	27	30
Homicide	2	1	0	0	1	0	1	4	0	0	15	12

Data Source: Washington State Department of Health, Statistics, and Death Certificates

South Central Region Total Licensed Vehicles and Licensed Drivers

County	Licensed Drivers	Passenger Vehicles	Trucks
Benton	102,617	93,653	35,199
Columbia	3,108	2,475	2,189
Franklin	30,295	30,354	15,250
Kittitas	23,954	18,820	11,775
Walla Walla	35,159	27,547	12,168
Yakima	143,251	132,345	61,510
Totals	**338,384**	**305,194**	**138,091**

1. Issues, Needs, and Weaknesses

Unintentional injury is the number one cause of death in people between 0 – 65 years in the State of Washington and in the South Central Region. The South Central EMS and Trauma Care Council has continually allocated resources for injury prevention projects for over a decade. State and regional injury data show that the injury problem persists as a regional and state problem. In an effort to reduce death and disability from injury in the South Central Region, injury prevention efforts remain a focus of the Regional Council and a funding target for the 2004-2005 biennium. A Regional Council direction is to increase awareness of potential injury incidents and attempt to change personal and public behaviors thus decreasing injury and death due to trauma. The Regional Council makes every attempt to measure the success of its injury prevention and public education programs, but there is a need for quantitative evaluation in the region

An additional **need** is for additional funding for all injury prevention and public education programs. The Regional Council has been able to increase the number of safety programs it sponsors each year by partnering with the four SAFE KIDS Coalitions within the South Central Region. The Regional injury prevention funds are divided among the coalitions to help facilitate their established programs. All injury prevention coalitions are exploring avenues for additional funding sources. National statistics show that grant funds are fewer, competition is enormous and grant applications are becoming very specific in nature.

Non-English speaking populations within the Region necessitate unique approaches to educate these populations about preventing injury. The Region has a large Spanish speaking population. In the last several years the area has also experienced an influx of Russian and Asian populations. Injury prevention and public education programs face challenges with non-English speaking people. The Regional SAFE Kids coalitions have addressed these issues by providing seasonal and resident Spanish speaking populations with safety messages printed in Spanish. Information for the Russian and Asian populations has not been as critical a need since they tend to rapidly transition to English. Injury

prevention programs will need to continue to adapt materials for various languages.

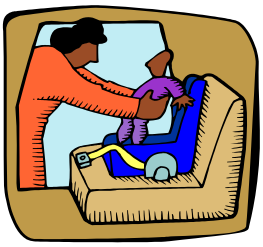
The different cultures of the Region also provide challenges to the development of injury prevention programs. There is a need to develop relationships with key members of different cultures. The Yakama Native American Reservation in Yakima County recently passed a reservation seat belt law, which was a major hard won accomplishment. The Yakama's are now working toward a child safety restraint law. The Yakima SAFE Kids coalition works with the tribe to provide several programs such as safety fairs and bike rodeos through reservation schools and in partnership with the Yakama Indian Health Service. The high school students on the Reservation utilize these events as their public service project and provide the manpower for booths and help with bike rodeos. Injury Prevention and Public Education information also is made available at such tribal events as Treaty Days and Pow Wows.

The Regional Council will make every attempt to measure the success of its injury prevention and public education programs, but there is a **need** for a concerted statewide effort to insure the most accurate information.

2. Injury Prevention Goals

Unintentional Injury
Need: Prevent injury and death associated with trauma**,** a leading cause of death in South Central Region from 0- 65 years of age.
Goal: Regional supported injury prevention programs addressing high-risk activities.
Objective 1. During the 2004-05 biennium, provide funding to the SAFE KIDS Coalitions in Kittitas, Yakima, Benton/Franklin and Walla Walla/Columbia Counties to support Injury Prevention programs that address activities that put the public at risk in the South Central Region.
Strategy: Complete Regional agreements with each coalition and provide monthly funding using an established formula based on population as follows: Kittitas, $412.50; Yakima, $825.00; Benton/Franklin, $825.00; and Walla Walla/Columbia, $687.50.
Objective 2. Work with SAFE KIDS coalitions to ensure South Central Region injury prevention problems are addresses by Regional Council supported programs in the biennium.
Strategy 1: Each SAFE KIDS coalition will provide to the Regional Council, an annual workplan of planned activities at the beginning of each fiscal year, monthly activity reports, and an annual report of actual activities that have been supported by the Regional Council at the end of each fiscal year.
Strategy 2: Coalitions will provide 80 safety and injury prevention messages and information on upcoming events to local newspapers and media. Copies of newspaper articles are provided in each coalition's monthly report.

Objective 3: Include seat belt use information at 20 safety events each year.
Strategy: Each Safe Kids Coalition will report the events where seat belt use is promoted and the approximate number of individuals contacted in monthly and annual reports.
Projected cost: It is difficult to identify costs for all of the programs provided by the four SAFE KIDS organizations. However, all have identified the high cost of advertising injury prevention programs. Costs range from a minimum of $300.00 to $1.000.00 depending on size and frequency of advertising.
Barriers: The ongoing barrier for all injury prevention programs is lack of funding and volunteers.



Motor Vehicle Crashes
Need: Motor vehicle crashes are the leading cause of death for ages 0 to 8 according to Washington State Injury Prevention data.
Goal Child safety restraints are used throughout the Region
Objective 1: Conduct 80 car seat clinics throughout the year within the Region.
Strategy 1: In one car seat clinic in each area once a month, provide free or low cost car seats to at risk low income families who cannot afford to purchase them.
Strategy 2: Each coalition will track and report the number of car seats clinics and seats checked, numbers of car and booster seats distributed, and the numbers of Child Passenger Safety Technicians train during the year in their monthly or annual reports to the Regional Council.
Objective 2: Facilitate planning for permanent car seat checkpoint sites within the Region at Washington State Patrol Offices in Kennewick (Benton County) and Kittitas County; at Yakima Valley Memorial Hospital (Yakima County); at the Walla Walla Fire Department (Walla Walla County) and Richland Fire Department (Benton County).
Objective 3: Provide 6 Child Passenger Safety Technician courses throughout the Region each year.
Strategy: Coalitions will determine the sites and include them in their annual workplan.
Projected costs: The coalitions estimate that the cost to put on a Car Seat Technician Training Class is at least $2,400.00. Each coalition puts on one or more training classes per year for a minimal estimated cost of $9,600.00 for four classes. Car and booster seats cost approximately $35.00 per seat. Each coalition distributes about 100 to 150 seats a year for an estimated of $21,000.00 for seat purchase.
Barriers: Resources to purchase car seats; volunteer to man the check stations; and the long physical distances between car seat clinics.

Falls in the Elderly

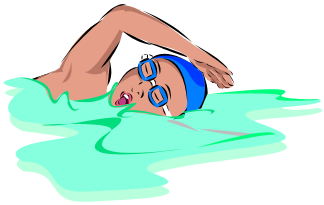
Need: Prevent fall the second leading cause of death and disability for people over the age of 65 according to the Washington State Injury Data from 1997 to 2001.
Goal: Citizens are informed about falls prevention for the elderly.
Objective: Facilitate 20 fall awareness programs throughout the Region during the year.
Strategy 1: Each SAFE KIDS Coalition at the request of the South Central Region EMS & Trauma Care Council has expanded their programs to include a "falls in the elderly prevention program" such as Benton/Franklin's *Visiting Grandmother's House* and *Tread to Safety* in Kittitas County.
Strategy 2: Work with already established coalitions such as NFPA "Remember when…." who have fall prevention programs and activities especially for the elderly.
Strategy 3: Include "Falls prevention" information at 20 health fairs and safety events during the year.
Strategy 4: Each coalition will provide the number and attendance information for fall prevention programs in their monthly or annual reports.
Strategy 5: Encourage the Mid Columbia EMS & Trauma Care Council to continue their "Tread to Safety" programs and distribution of their Falls Prevention brochure within the Tri Cities area.
Projected Cost: It is difficult to estimate the costs related to this program.
Barriers: The ongoing barrier for all injury prevention programs is lack of funding and volunteers to continue the programs.

Head Injury

Need: Increase the use of bicycle and all sport helmets to prevent or lessen serious head injuries.
Goal: Helmet usage throughout the Region protects against serious head injury.
Objective 1: Facilitate 80 Safety Helmet Use & Safety Education Programs throughout the Region each year of the biennium.
Strategy 1: Hold one SAFE KIDS helmet information give-away event twice annually in each county during 2003-2005.
Strategy 2: Each SAFE KIDS coalition will provide monthly or annual reports with the number of children/adults educated, and number of helmets distributed at safety events
Objective 2: Encourage and promote the increased use of bike helmets and "all" sports helmets among the children, teenagers, young adults, and adults of the South Central Region at a minimum of two sports event in Benton/Franklin counties each season.

Strategy 1: The SAFE KIDS Coalitions in Benton/Franklin and Walla Walla Counties will work with the Tri Cities American Hockey team and the Dust Devils baseball team to advertise SAFE KIDs and provide game tickets as prizes at least one game each during their seasons.
Strategy 2: Post supported events on Regional Web-site.
Projected cost: The projected cost of helmet purchase for the four SAFE KIDS Coalitions is over $8,000. The Benton/Franklin SAFE KIDS have developed a head injury training kit that costs $45.00 each. They have distributed seven of them within their area for a cost of $315.00.
Barriers: The ongoing barrier for all injury prevention programs is lack of funding for bike helmets and volunteers to fit helmets and run the bike rodeos.

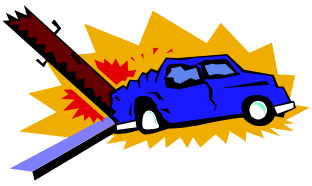
Poisoning
Need: Prevent poisoning, the third leading cause of death in the South Central Region according to the Washington State Injury Data from 1997 to 2001.
Goal: Kids are protected from accidental poisoning.
Objective: The SAFE KIDS Coalitions will provide at least 4 poisoning prevention programs during Poisoning Prevention Week each year.
Strategy 2: Each of the four coalitions will provide at least one poisoning prevention program during Poisoning Prevention Week each year.
Projected costs: It is difficult to calculate the cost of these programs because they are often incorporated with other programs.
Barriers: The ongoing barrier for all injury prevention programs is lack of funding and volunteers.



Drowning
Need: Prevent drowning, the fourth leading cause of death in the South Central Region per the Washington State Injury Data from 1997 to 2001.
Goal: Drowning deaths are prevented in the South Central Region.
Objective 1: Support drowning programs that reduce the risk of drowning for kids and adults during the biennium.
Strategy 1. Annually facilitate 10 Drowning prevention programs such as "Kids Don't Float" program within the Region.
Strategy 2: By the end of the biennium, provide 8 to 12 personal floatation devices per Drowning Prevention Board located at the Kids Fishing Ponds in Columbia Park and at the Richland Fire Department in Benton County, at Sacejewea State Park in Franklin County, at

Yakima Fire Station #10 in Yakima, at Vantage State Park in Kittitas County, at Lions Ferry State Park and Central Ferry State Park in Columbia County, and at Hood, Fishhook, and Charboneau State Parks in Walla Walla County.
Strategy 3.: Work with the Corps of Engineers to place Drowning Prevention Boards in 3 of their parks along the Snake River in Franklin County.
Strategy 4: Work with the Corps of Engineers and other coalition members to provide drowning prevention education and activities.
Strategy 5: Attempt to track the number of "Kids Don't Float" PFDs used, the number of water safety presentation provided, and the number of PFDs at low or no cost provided throughout the year.
Projected Costs: One coalition estimates it costs over $1,000.00 to make, equip and install a Drowning Prevention Board. The Corps of Engineers is helping to establish Drowning Prevention Boards at several locations along the Snake River.
Barriers: Project development issues and funds for the purchase of additional PFDs.

Pedestrian Safety
Need: Prevent pedestrian fatalities, the fifth cause of death within the Region per the Washington State Injury Data from 1997 to 2001. The Regional Council has developed a unique program, Wildfeet, to increase visibility for especially for children during low light hours when most pedestrian incidents occur.
Goal: Child pedestrian deaths are prevented in the Region**.**
Objective 1: Decrease the rate of child pedestrian deaths during the biennium through pedestrian safety programs.
Strategy 1: SAFE KIDS Coalitions will provide Wildfeet, a retro-reflective stickers for backpacks, bikes, etc, at 20 safety events within the Region per year.
Projected cost: At this time there are few costs associated with this program. The retro-reflective material is scrap from DOT and the labor is by Yakima County jail inmates. The only cost is occasional repair of the stamping machine and small bags for the Wildfeet stickers.
Barriers: At this time, there are no barriers to this project.



Impaired Drivers Awareness
Need: Local statistics show that impaired drivers cause 42 % of MVA crashes.
Goal: Deaths from impaired drivers are preventable.
Objective 1: Support two DUI Coalition programs during the biennium to increase awareness of impaired drivers.

Strategy 1: Continue the established agreements and provide a pass through grant for $4,170.00 for the DUI Coalitions in Walla Walla for a "Tie One On For Safety" and "Drunk Drivers Are Out There" programs in Walla Walla and Columbia Counties.
Strategy 2: Continue the established agreement and provide a pass through grant for $2,500.00 to the Benton/Franklin DUI Coalition for "Every 15 Minuet" programs in Benton and Franklin Counties.
Objective 2: Track coalition activities during each year.
Strategy: The coalitions will provide periodic and final program report to the South Central Region that will be forwarded to DOH.
Projected Cost: The Regional Council is facilitating two DUI grants, one to Walla Walla County for $4,170.00 and one to Benton/Franklin County for $2,500.00. Much more could be done if more funds were available.
Barriers: The ongoing barrier for all injury prevention programs is lack of funding and volunteers.

3. Activity Measurements are listed under "strategies in each goal listed above.

IV. PRE-HOSPITAL

A. Communication

1. Issues/Needs/Weaknesses

Some elements of prehospital communication work well in the South Central Region, however, in spite of these successes, the Regional Council has long recognized that there are significant issues related to Emergency Medical and Trauma System communications in the Regional system. Communication system improvements are complicated. and require interagency collaboration. The Region's unique physical topography and the funds needed to purchase land for communication towers and radio equipment for both EMS and Trauma Services are significant.

a. Public Access (911, E911, etc.)

There are no major issues related to public access in the South Central Region. Telephone access of 9-1-1 is the most frequently used method for the public to access the EMS system or to report emergency situations throughout the region. E 9-1-1 dispatchers are available in all counties within the South Central Region and centralized E 9-1-1 centers have been established in most areas. All counties have completed the re-addressing of their rural areas making it easier for EMS and emergency personnel to find specific locations. The following is a list of South Central Region Dispatch Centers:

- **Columbia County**
  Columbia County Sheriff Department Dispatch Center, located in the City of Dayton, receives emergency calls and dispatches EMS for all of Columbia County and EMS in Walla Walla Fire District #2.
- **Kittitas County**
  Kitt Comm, located in the City of Ellensburg, receives emergency calls and dispatches all EMS for Kittitas County
- **Benton County**
  Southeast Communication Center, located in the City of Richland, receives emergency calls and dispatches EMS for the eastern portion of Benton County.
  Prosser Police Dispatch Center, is located in the City of Prosser, receives emergency calls for the southwestern portion of Benton County and provides dispatch information to American Ambulance.
- **Franklin County**
  Franklin County Sheriff Dispatch Center, located in the City of Pasco, receives emergency calls and dispatches EMS to all of Franklin County.

- **Walla Walla County**
  Walla Walla Emergency Dispatch Center, located in the City of Walla Walla, receives emergency calls and dispatches EMS in all of Walla Walla County.
- **Yakima County**
  Yakima Public Communications Center, located in the City of Yakima, answers 9-1-1 calls and dispatches EMS for all Upper Yakima County.
- **Yakima Valley Fire District #5 Dispatch Center,** located in the City of Toppenish receives emergency calls and dispatches EMS for the Lower Yakima Valley.

b. Dispatch

Emergency dispatchers are usually the first link of the EMS and trauma system activation. Emergency dispatchers provide EMS responders with essential information concerning the location and nature of the emergency calls. National statistics show that centralized dispatch centers and Emergency Medical Dispatch trained dispatchers provide *quicker* EMS dispatching, provide *better* information and *more accurate* directions for EMS responders and *save lives* by providing pre-arrival instructions.

In the South Central Region the primary need related to dispatch is for continued Emergency Medical Dispatcher (EMD) training.

1. **Training for Dispatch Personnel**
   Emergency Medical Dispatch training is needed within the Region. Most dispatch centers find it very difficult to send personnel out of the Region for training. The Regional Council encourages Regional dispatch centers to utilize nationally recognized dispatch training such as Criteria Based Dispatch (CBD) or Medical Priority Emergency Medical Dispatch training utilizing E 9-1-1 funds.

2. **Dispatch Prioritizing**
   Part of EMD training is dispatch prioritizing. All Emergency Dispatch Centers within the Region utilize a recognized process for dispatch prioritizing. The need continues to be for EMD training to assure the dispatch prioritizing continues.

3. **Provisions For Bystander Care With Dispatcher Assistance**
   EMD training provides an organized structured methodology for providing Bystander Instructions for emergency care. The need continues for EMD training availability throughout the Region.

4. **Patient Care Procedure #1 Dispatch**
   The Regional Council developed Patient Care Procedure #1, Dispatch to address the **need** for timely emergency dispatch and minimize the "dispatch interval" and to get trauma trained EMS personnel to the scene of an incident

as soon as possible.

c. Primary and Alternative Communication Systems

In eastern Washington, including the South Central Region, the VHF HEAR radio frequency is the primary EMS communication frequency. The EMS agencies within the Region continually strive to improve and update their current VHF HEAR equipment.

Cellular telephones also are a popular tool for EMS agency to trauma service communication. Many Regional trauma services have established dedicated telephone lines for EMS calls from the field. In some remote areas, EMS providers have found that they can establish cellular telephone contact where radio systems failed.

Problems with prehospital communication with hospitals are predominantly in remote rural areas where neither cell phone nor radio will reach the receiving hospitals. Ambulances must wait until they are in cell phone or radio range. This is an ongoing problem requiring a statewide solution.

d. System Operations During Single and Multiple Patient, Mass Causality and Disaster Incidents

In most locations throughout the Region, the HEAR Radio is the primary communication source for EMS in single, multiple, mass causality or disaster incidents. It is often necessary for EMS providers to communicate with other agencies such as law enforcement, fire departments, and public utility agencies while in route or at the scene of an emergency call. In most locations, EMS, fire departments, and law enforcement agencies utilize different radio frequencies. While some EMS agencies carry frequencies used by police and state patrol, in other areas, the communication link must go through the emergency dispatch centers. EMD training for dispatchers once again becomes crucial to providing accurate current information and coordination of communication at EMS scenes. The advent of cell telephone technology has provided an additional direct line that can be used by multiple agencies for direct communications with each other. Each county has at least one disaster drill a year, and problems with the communication systems continue to be an ongoing problem.

The HEAR frequency, 155.340 MHz, has two frequencies designated for the HEAR system, one for EMS field communications with trauma service's emergency departments and the other for inter-hospital communication (hospital to hospital), 155.280 MHz. A problem has developed over time with the hospitals utilizing the second frequency as a paging system for "on call" or "in-house" hospital personnel. Few hospitals have written policies or practiced any radio communication plans with other hospitals. Regional trauma services surveyed stated that they have never tested the HEAR system to see if radio communications can be established with other Regional trauma services. Current interfacility communications are exclusively by telephone contact.

e. Roles of Other Public & Private Agencies

All counties are mandated by RCW to have mass casualty disaster plans developed by their County Emergency Management Departments. These disaster plans address such topics as EMS response, health care facility response and emergency communications resources. There is a general need for County disaster plans to ensure that the EMS portion of their plans reflect the current EMS and Trauma System. Communication incompatibilities between public and private agencies are issues in the Region that require a statewide solution.

f. Evaluation of Communication Systems per Table A

TABLE A

Communication Center Survey	**Benton County** Southeast Communication Center**,** located in the City of Richland, receives emergency calls and dispatches EMS for the eastern portion of Benton County.
1. Citizen Access	Yes 9-1-1
2. Consolidated	No
3. # Employees	33
4. # Not Trained	0
5. Kinds of Training & how often	Yearly access, special operations and CBD/EMD as required
6. On-going Training	Yes
7. Kinds of Protocols	King County CBD
8. Med. Director involvement	Yes, EMS MPD review and approval
9. Dispatch Prioritizing	CBD life threat, emergent, non emergent
10. Bystander Care	Yes
11. Pre-arrival Instructions	Yes
12. Quality Assurance	In the process of developing
	Prosser Police Dispatch is located in the City of Prosser, receives emergency calls for the southwestern portion of Benton County and provides dispatch information to Prosser Memorial Ambulance.
1. Citizen Access	Yes 9-1-1
2. Consolidated	no
3. # Employees	7
4. # Not Trained	0
5. Kinds of Training & how often	Monthly EMD and other dispatch related topics
6. On-going Training	Yes
7. Kinds of Protocols	King County CBD
8. Med. Director involvement	Yes, EMS MPD reviews and approves
9. Dispatch Prioritizing	In accordance with CBD
10. Bystander Care	Yes
11. Pre-arrival Instructions	Yes
12. Quality Assurance	Yes
12. Quality Assurance	Unknown

	Franklin County Sheriff Dispatch Center, located in the City of Pasco, receives emergency calls and dispatches EMS to all of Franklin County.
1. Citizen Access	Yes 9-1-1
2. Consolidated	no
3. # Employees	12
4. # Not Trained	0
5. Kinds of Training & how often	Monthly EMD and other dispatch related topics
6. On-going Training	Yes
7. Kinds of Protocols	King County CBD
8. Med. Director involvement	Yes, EMS MPD reviews and approves
9. Dispatch Prioritizing	In accordance with CBD
10. Bystander Care	Yes
11. Pre-arrival Instructions	Yes
12. Quality Assurance	Yes

	Kitt Com Dispatch is located in the City of Ellensburg and answers 9-1-1 calls and dispatches all EMS calls in Kittitas County.
1. Citizen Access	Yes 9-1-1
2. Consolidated	Only dispatch in Kittitas County
3. # Employees	17
4. # Not Trained	0
5. Kinds of Training & how often	Monthly EMD and other dispatch related topics
6. On-going Training	Yes
7. Kinds of Protocols	Priority Dispatch
8. Med. Director involvement	Yes, EMS MPD reviews and approves
9. Dispatch Prioritizing	In accordance with Priority Dispatch
10. Bystander Care	Yes
11. Pre-arrival Instructions	Yes
12. Quality Assurance	Yes

	Walla Walla Police Dispatch is located in the City of Walla Walla and answers 9-1-1 calls and dispatches all EMS calls in Walla Walla County.
1. Citizen Access	Yes 9-1-1
2. Consolidated	Only dispatch in Walla Walla County
3. # Employees	15
4. # Not Trained	0
5. Kinds of Training & how often	Monthly EMD and other dispatch related topics
6. On-going Training	Yes
7. Kinds of Protocols	King County CBD
8. Med. Director involvement	Yes, EMS MPD reviews and approves
9. Dispatch Prioritizing	In accordance with CBD
10. Bystander Care	Yes
11. Pre-arrival Instructions	Yes
12. Quality Assurance	Yes

	Yakima County Yakima Com Center Upper Valley, located in the City of Yakima, answers 9-1-1 calls and dispatches EMS for all Upper Yakima County.
1. Citizen Access	Yes 9-1-1 answered by Yakima County PSAP and forwarded to this dispatch
2. Consolidated	Yes
3. # Employees	24
4. # Not Trained	1
5. Kinds of Training & how often	Monthly in-house case reviews, weekly TTY, yearly EMD requirements
6. On-going Training	Yes
7. Kinds of Protocols	King County CBD
8. Med. Director involvement	In the past, not currently
9. Dispatch Prioritizing	CBD life threat, property threat, no threat
10. Bystander Care	Yes
11. Pre-arrival Instructions	Yes
12. Quality Assurance	No

	Yakima Valley Fire District #5 Dispatch Center, located in the City of Toppenish receives emergency calls and dispatches EMS for the Lower Yakima Valley.
1. Citizen Access	Yes 9-1-1
2. Consolidated	No
3. # Employees	15
4. # Not Trained	0
5. Kinds of Training & how often	Monthly EMD and other dispatch related topics
6. On-going Training	Yes
7. Kinds of Protocols	King County CBD
8. Med. Director involvement	Yes, EMS MPD reviews and approves
9. Dispatch Prioritizing	In accordance with CBD
10. Bystander Care	Yes
11. Pre-arrival Instructions	Yes
12. Quality Assurance	Yes

2. Communication Goals

Need: Improved trauma system communications.

Goal 1: Day to day and disaster communication capabilities between emergency dispatch and EMS vehicles and hospitals, and between EMS agencies and other responding entities.

Objective 1: During 2003-2005, the Regional Council will help to identify geographic areas where "black holes" continue to make radio and landline, and cell phone communication impossible.

Strategy: Participate in regional or statewide communications assessments. The following areas have been identified as having communication needs:

- Franklin County PHD #1 Ambulances in North Franklin County,
- Franklin County FD #2 Ambulance in Kahlotus,
- Yakima County FD #5 with many stations on the Yakama Reservation,
- Yakima FD #3 in Naches
- Yakima FD #14 on Chinook Pass.

Objective 2: Promote and encourage new equipment and technology to enhance local emergency medical communication systems during the biennium.
Strategy: Assist the high need agencies in the region with Trauma System EMS "needs grants" or other communication grants to meet some of their communication needs.
Projected Cost: The cost of new communication towers and equipment to improve communications within the Region is estimated to be many hundreds of thousands of dollars.
Barriers: Fixing communication problems is very expensive and out of the range of either local or Regional EMS & Trauma Care Councils. In some areas, new communication towers, the land where they would be located, and improved communications equipment both in ambulances and at the hospitals, would be necessary to improve EMS communications. All of the possible "fixes" would cost many thousands of dollars.

Goal 2: Trained Emergency Medical Dispatchers handle EMS calls in all dispatch centers in the region.
Objective 1: At least annually promote and encourage Criteria Based Dispatch/EMD training or other nationally recognized EMD training courses.
Strategy 1: Forward to the Dispatch Centers any information that comes through the Regional Council office on EMD training classes.
Barrier: All Regional emergency dispatch centers share the inherent weakness of high attrition rate of emergency dispatchers. Most dispatch centers are finding it necessary to provide EMD training for newly hired dispatchers about every six months.
Strategy 2. Include dispatch center personnel in regional communication planning and CQI meetings.
Strategy 3. Work with Dispatch agencies during the biennium to develop a CQI method to determine how successful EMD/CBD criteria are and the effectiveness of pre arrival instructions.
Barrier: Dispatch agencies are under no obligation to work with or provide information to EMS, hospitals or the Regional Council.
Objective 2: Encourage Dispatch Centers to provide pre-arrival instructions that range from simple first aid to life saving instructions such as unconscious/breathing normally, CPR, choking, and childbirth.
Strategy 1: Include dispatch agency participation in Regional communication planning committees.
Strategy 2: Forward to the Dispatch Centers any information that comes through the Regional Council office on EMD pre-arrival instructions.
Projected Costs: Encourage Dispatch Centers to utilize E 9-1-1 funds for Emergency Medical Dispatch training.
Barrier: Lack of EMD trained dispatchers limits using pre-arrival instructions.

Goal 3: Timely Emergency Medical Dispatch throughout the South Central Region
Objective: At least annually, promote the use of Regional PCP # 1 "Dispatch" to minimize the "dispatch interval" and to get trauma trained EMS personnel to the scene of an incident as soon as possible.
Strategy 1: Include Dispatch personnel in regional CQI meetings.
Strategy 2: Review, update and distribute to dispatch centers, Regional PCPs on a regular basis and as needed.
Projected Costs: Encourage Dispatch Centers to utilize E 9-1-1 funds for EMD training,

Barrier: Continued lack of EMD training for emergency dispatchers.

Goal 4: Formalized CBD/EMD CQI programs are integrated with EMS and Trauma System CQI activities.
Objective: On an ongoing basis, encourage EMS and Regional CQI to invite Emergency Dispatch Centers to participate at both the local and Regional level of CQI activities.
Strategy 1: Participate in the identification of prehospital agencies with CQI programs as part of regional surveys.
Strategy 2: Include dispatch personnel in regional CQI planning.
Strategy 3: Provide available CQI dispatch information to dispatch centers for their use in formalizing CQI efforts.
Projected Costs: It is difficult to estimate the cost of this goal.
Barriers: Most dispatch centers have not established internal CQI programs and are not yet motivated to participate in CQI at a local or Regional level. There is no requirement for dispatch centers to participate in local or regional CQI programs.

Goal 5: All disaster plans in the South Central Region are up to date and testing is collaborative.
Objective 1: Request the local councils to notify the Regional Council office when County disaster plans are tested annually.
Strategy: Develop a regional request for information form and a mailing timeline.
Objective 2: Request Regional Trauma Services to notify the Regional Council office when they have their required two disaster drills a year. All disaster drills include EMS agencies and communications centers.
Strategy: Develop a Regional request for information form and a mailing timeline.
Projected Cost: It is difficult to identify the costs involved in disaster drills due to the diversity of the agencies and trauma services and their levels of involvement.
Barrier: The local Councils, EMS agencies and Trauma Services do not routinely report disaster drills to the Regional Council office.

B. Medical Direction of Prehospital Providers

1. Issues, Needs and Weaknesses

DOH appoints a physician in each county to provide medical direction of prehospital personnel. These physicians are called Medical Program Directors (MPDs). MPDs provide the legal authority for Paramedics, EMTs including ILS, IV and Airway, and First Responders to administer patient care within their county or jurisdiction. MPDs have developed written patient care protocols that describe and regulate the scope of practice and medical treatment for EMS. MPDs review, revise and update their protocols on a regular basis. WAC states that local MPD patient care protocols are not to be in conflict with Regional PCP's. Regional PCPs are to be the foundation for MPD patient care protocols as well as for COPs. COPs are developed when a county determines that more direction is needed to specify how Regional PCPs will be used throughout their county. MPDs participate in local EMS & Trauma Care Council meetings and issues. However, MPDs do not attend or actively participate in Regional Council meetings. The Regional Council provides MPDs with the opportunity to have input into Regional PCPs and Trauma System Plan update. Historically MPD input is funneled through local council participation.

2. Medical Direction of Prehospital Goals

Goal: Active MPD participation the Regional Council.

Objective: Continue to encourage MPD participation in Regional Council, development of trauma plan and updates and input into Regional Patient Care Procedures during the biennium.

Strategy 1: Provide MPDs will all Regional Council mailings such as Council minutes and drafts of all PCPs and trauma plan updates.

Strategy 2: Consult with MPDs and determine the two most useful things that the Regional Council can do to increase their Regional system participation such as possible phone conferencing or an agenda that isolates the MPD time committment.

Projected Cost: Each MPD receives a stipend of $4,800.00 per year from DOH. In no way does this cover the cost of their time in providing direction to EMS. Perhaps if MPDs were compensated for attending local and Regional EMS & Trauma Care Council meetings, participation would be greater.

Barrier: MPDs show little interest in participating with the Regional Council.

Regional Medical Program Directors

- **Columbia County-**Dr. Michael Luce, Dayton
- **Benton & Franklin Counties-**Dr. Joe Loera, Kennewick
- **Kittitas County-**Dr. Jack Horsley, Ellensburg
- **Walla Walla County-**Dr. Adrian Selfa, Walla Walla
- **Yakima County-**Dr. Eric Miller, Yakima

C. Prehospital EMS and Trauma Verified Services

Demographics:

South Central Region Population

Total Population	Male	Female
1999 - 487,500	243,725	243,775
2000 – 513,000	257,357	255,643

Total Land Area	Incorporated Area	Unincorporated Area
11,678 sq. miles	166.42 sq. miles	11,511.58 sq. miles
Total Population	**Population in Incorporated Area**	**Population in Unincorporated Areas**
513,000	331,455	171,996

1. Issues, Needs and Weaknesses

The Regional Council has long recognized that long response and transport times due to the large rural and wilderness, areas are an inherent **weakness** of the trauma system. The very wide-open spaces that make this region appealing to its residents can cost precious time during the "golden hour" for a severely injured trauma patient. With that in mind the Regional Council developed the following goals:

a. Current EMS/TC Personnel Resources

The South Central Region has an integrated network of prehospital EMS and trauma

verified services within the region. The mix includes both paid professional and volunteer agencies. Trained providers include First Responders, EMT's and Paramedics. Long response and transport times due to the large rural and wilderness, areas are hallmarks of the regional system. Timely EMS response, especially for trauma patients, is needed in the Region. A three-tiered EMS response system would ensure timely response and is a target for regional planning in the biennium.

While the regional system is integrated and functional, a significant issue in the region is the steady decrease in EMS volunteers. This is a major problem because 76% of EMS personnel are volunteers. The Region's EMS and Trauma Care System Plan identifies areas where EMS services need to be established or levels of present EMS services need to be increased. Ensuring an adequate number of EMS providers to provide EMS response and transport is an ongoing focus of the Council. More volunteer EMS providers are needed.

FY 2003 Current EMS Personnel Resources by County and Level

Columbia County

Amb	Level	FAV	Level	FR	EMT	IV	AW	IV/AW	PM	Pd	Vol
2	BLS	2	BLS	6	31	0	1	1	0	1	38

Total Columbia County EMS Providers 39

Benton County

Amb	Level	FAV	Level	FR	EMT	IV	AW	IV/AW	PM	Pd	Vol
21	ALS								69		
13	BLS	12	BLS	113	309	31	0	0		250	272

Total Benton County EMS Providers 522

Franklin County

Amb	Level	FAV	Level	FR	EMT	IV	AW	IV/AW	PM	PD	Vol
3	ALS								13		
5	BLS	6	BLS	20	110	1	0	1		42	100

Total Franklin County EMS Providers 145

Kittitas County

Amb	Level	FAV	Level	FR	EMT	IV	AW	IV/AW	PM	Pd	Vol
5	ALS								12		
2	BLS	6	BLS	30	98	5	0	0		31	114

Total Kittitas County EMS Providers 145

Walla Walla County

Amb	Level	FAV	Level	FR	EMT	IV	AW	IV/AW	PM	Pd	Vol
5	ALS								22		
5	BLS	12	BLS	21	135	16	2	2		57	141

Total Walla Walla County EMS Providers 198

Yakima County

Amb	Level	FAV	Level	FR	EMT	IV	AW	IV/AW	PM	Pd	Vol
22	ALS								43		
4	ILS										
2	BLS	91	BLS	190	361	26		13		175	458

Total Yakima County EMS Providers 633

Total Regional EMS Providers 1,681

b. Prehospital Training Resources

The Regional Council facilitates EMS training, CME and OTEP through contracts with the local EMS and Trauma Care Councils. This system of delivering prehospital education continues to be a real strength within the Region. Each local council has a training program, either the Regional OTEP program or another state approved OTEP program, that fulfills all requirements for EMS training and education. Updated OTEP training is needed in the Region.

Regional Council training contracts help local agencies with their need to maintain current EMS personnel levels through basic EMT and First Responder training. However, in the South Central Region EMS volunteers are still decreasing. This is a major problem in an area where 76% of EMS personnel are volunteers. The Regions EMS and Trauma Care Plan identifies areas where EMS services need to be established or levels of present EMS services need to be increased. The Regional and the local EMS & Trauma Councils are continually working together to meet those needs through initial EMS training.

c. Prioritizing and conducting Prehospital Training

Each local EMS & Trauma Care council evaluates its EMS training needs each year, develops a workplan that addresses those needs, and submits their workplan with budgets and class schedules to the Regional Council. Each workplan is reviewed by the Regional Training and Education Committee and accepted by the Regional Council. EMS and Trauma grant funds for training are then distributed to each local council using a formula based on square miles and number of EMS providers in each local council area. This system has been working well for several years. The Regional Training & Education Committee has been in the process of updating the Regional OTEP. Adequate funding to support the volunteer training needs is an ongoing issue.

d. Additional Public Safety Personnel

Affiliated EMS agencies provide vital emergency response link with EMS agencies. WAC defines an affiliated agency as an agency that is not required to be licensed, but is recognized as a participant in Regional Trauma system. These agencies include ski patrols, dive rescue organizations, law enforcement, search and rescue organizations, hazardous material teams, and many others. Personnel from affiliated agencies must meet Regional CME and OTEP requirements for certification.

Affiliated agencies provide additional resources to EMS agencies. These agencies provide additional EMS personnel and often are on scene at their place of employment or in specialized areas or specific locations prior to the arrival of regular EMS. There is a

regional need to ensure that affiliated agencies continue as part of the overall system. No specific needs for these agencies have been identified within the planning process this biennium. The following are the Affiliated Agencies within the South Central Region:

Columbia County:
Dayton Fire Department
Bluewood Ski Patrol

Kittitas County:
Kittitas County Sheriff Search & Rescue
Roslyn Police Department
Senior EMT Instructors - Central Washington University
Kittitas County EMS Division

Mid Columbia:

Benton County
Benton County Fire District #3
Benton County Sheriff
Washington Power Supply System
Columbia Basin Dive Rescue
Mid Columbia Pre-Hospital Care Association
Sr. EMT Instructors Benton County

Franklin County
Simplot

Walla Walla County:
D&K Foods
Walla Walla County Sheriff
Walla Walla Police Department
Spout Springs Ski Patrol
Walla Walla Regional Airport
Washington State Patrol
Department of Natural Resources
Oregon Forest Service
Milton-Freewater Rural Rescue

Yakima County:
Washington State Department of Ecology
Yakima Air Terminal
Department of Natural Resources
National Ski Patrol
Tieton Police Department
Yakima County Search and Rescue
Yakima Training Center Fire Department
Yakama Indian Agency
Yakima County EMS
Yakama Nation Branch of Forestry

Other Agencies Involved In Specific Elements of Trauma System Planning and Development

Hanford Nuclear Reservation provides ALS ambulances that respond to EMS incidents on the site and near their borders.

Columbia Basin Dive Rescue (CBDR) provides emergency water rescue service and assist with water recoveries of drowning victims, criminal evidence, autos, etc, for Benton, Franklin, Walla Walla Counties and Umatilla and Morrow Counties in the Oregon State.

The U.S. Army MAST Helicopter Unit from the Yakima Training Center provides emergency helicopter rescues for remote wilderness incidents in Yakima and Kittitas Counties.

The U.S. Army Umatilla Chemical Depot, a nerve gas storage site located in Oregon State provides bi-state disaster planning, training, and drills as part of the Chemical Stockpile Emergency Planning Process (CSEPP) plan for destruction of nerve gas.

Volpentest Hazardous Materials Management Emergency Response (HAMMER) Training Facility is a unique training facility located in Richland that is involved in advanced training for emergency response agencies of all kind.

Yakama Native American Reservation
The South Central Region has one Native American Reservation, the Yakama Indian Nation. This Reservation covers a large portion of Southern Yakima County and has several small towns, vast areas of wilderness with limited access, and high incident of traffic related crashes and fatalities.

Educational Institutions
Educational institutions play an important role in Regional trauma system development by providing both EMS and health care provider training and education. The following Regional colleges provide EMS and trauma service education:
Walla Walla Community College, Walla Walla, WA.
Provides a Nursing program, EMT, First Responder and Paramedic training.
Columbia Basin Community College, Pasco, WA.
Provides a Nursing program, a Paramedic program, and EMT and First Responder training.
Yakima Valley Community College, Yakima, WA.
Provides a Nursing program.
Central Washington University, Ellensburg, WA.
Provides a Paramedic program and EMT training.

2. Prehospital EMS & Trauma Verified Services Goals
Goal: Timely ALS care for trauma and medical patients
Objective: Continue establishing the three-tiered EMS system of BLS First Responder Aid services followed by BLS ambulance response, followed by ILS/ALS ambulance response.
Strategies: Utilize the Regional Council's Planning & Standards Committee to identify the current status, what is needed for the three-tiered system and the steps to be taken in the Region in 2003-04 and 2004-05.
Projected Cost: The Regional Council provides each county with the following grants to

provide ongoing EMS training and education, Columbia County, $3,414.00, Kittitas County, $10,621.00, Mid Columbia (Benton/Franklin Counties) $24,658.44, Walla Walla County, $8,724.58 and Yakima County, $28,449.73. The Regional Council also encourages and assists the EMS agencies in their process of applying for EMS Needs Grants.
Barriers: Establishing EMS agencies and increasing EMS skills levels are costly in purchase of EMS equipment and training of employees or volunteers.

Goal 2. More volunteer EMS Providers in rural areas of the region.
Objective: Provide initial training for EMS providers each year, especially in areas where EMS volunteers are declining.
Strategy 1: Through the contracts with local EMS & Trauma Councils, provide five or more EMT or First Responder training courses, especially in targeted areas.
Strategy 2: Collect information on basic EMT and First Responder training monthly from each county to monitor training in areas that have been targeted for increased volunteers.

Goal 3: A strong EMS CME and OTEP Program exists throughout the South Central Region.
Objective: Provide EMS training through contracts with the local EMS & Trauma Care Councils.
Strategy 1: Distribute trauma system grants to the local EMS & Trauma Care Councils using an established formula of numbers of EMS providers in each area and the land area. Distribution is as follows: Columbia County - $3,414.00, Kittitas County - $10,621.00, Mid Columbia (Benton/Franklin Counties) - $24,658.44, Walla Walla County - $8,724.58 and Yakima County - $28,449.73
Strategy 2: Provide 500 or more CME and OTEP classes each year across the Region in locations determined by the local councils.
Strategy 3: Track EMS Training and Education contract activity through submission of local councils annual workplan and monthly EMS Training reports.
Projected Costs: It is difficult to project exactly how many additional classes could be utilized in the local council areas or how much additional EMS equipment is needed. The Regional Council has been working with the local councils and EMS agencies for a number of years to access additional training and equipment through EMS Needs Grants.
Barriers: Need for more funding to provide more classes and purchase up to date training equipment.

Goal: The South Central has a state-of-the-art Regional OTEP Program.
Objective 1: The Regional Council will distribute an updated Regional OTEP program in Fall 2003.
Strategy 1.: The Regional Training and Education Committee will develop and recommend OTEP modules changes to the Regional Council and MPDs in 2003.
Strategy 2: The Regional Training and Education Committee will identify needs for training aids (etc) and make recommendations to the Regional Council in 2003.
Objective 2: The Regional Council will evaluate the new OTEP program in 2003-2005.
Strategy 1: The local EMS & Trauma Care Councils will provide monthly reports to the Regional Council on use of updated OTEP program.
Strategy 2: The Regional Councils Training and Education Committee will track issues and propose OTEP changes to the Council**.**
Projected Cost: It is difficult to identify the cost of Regional Council Member's time to

assist in updating the OTEP modules.
Barriers 1: The time needed for Regional Council members to devote to updating the modules is a potential barrier to success.
Barrier 2: Lack of funding for additional training materials and equipment.

D. Verified Aid and Ambulance Services

1. Current Status

The scope of trauma care offered by EMS providers in the South Central Region ranges from First Responders to Paramedics. In rural areas, EMS is provided by BLS agencies. In suburban areas, EMS is provided by ILS and ALS agencies. The most EMS resources are available in the four urban/suburban cities of Yakima, Walla Walla, Ellensburg, and the Tri-Cities (Kennewick, Pasco, Richland).

a. Current geo-political areas used to authorize EMS services

Regional and local EMS & Trauma Care Councils identified specific geographic service areas using established and recognized fire district boundaries. It must be understood that the use of these boundaries does not mandate that the fire districts must deliver EMS care. The levels of EMS services recommended for these un-serviced and under-serviced areas are included in the minimum and maximum service recommendations. Barriers to establishing these EMS services include political climate, lack of human and financial resources, and low EMS call volume.

b. The Need for and Distribution of Services Recommended to provide EMS services

The Regional Council asked each local EMS & Trauma Care Council to carefully evaluated existing EMS services, geographic location served, EMS response times, numbers of trauma calls, and possible future needs when making their recommendations to the Regional Council for minimum and maximum numbers and levels of EMS services. The Regional Council was very aware of the need to prevent the inefficient duplication of services. After careful evaluation, several local EMS & Trauma Care Councils identified areas where there was a need for EMS agencies to increase EMS skills and trauma verification levels. The Regional and local EMS and Trauma Care Councils identified specific geographic service areas using established and recognized fire district boundaries. It must be understood that the use of these boundaries does not mandate that the fire districts must deliver EMS care. The levels of EMS services recommended for served and under-serviced areas are included in the minimum and maximum service recommendations. Barriers to establishing these EMS services include political
climate, lack of human and financial resources, and low EMS call volume.

Below are the current status and EMS goals per county to meet identified needs or weaknesses

Columbia County

Columbia County has 869 square miles and is classified as rural with large portions of wilderness.

Columbia County Ambulance, an all-volunteer, private non-profit BLS ambulance,

provides service to the town of **Dayton** and all of Columbia County. This agency has two units and is the only ambulance service for Columbia County. The City of Walla Walla Fire Department ALS ambulance provides ALS rendezvous

Need: ILS* or ALS* trauma verified ambulance service in Columbia County. *Columbia County Ambulance* is the only ambulance transport service within Columbia County.
Goal: Increased skill levels for Columbia County Ambulance through Regional and local Councils recommendations as reflected in the maximum of 1 ILS and/or 1 ALS ambulance service in Columbia County's maximum numbers of Transport Services.
Objective: Encourage increased service levels for Columbia County Ambulance in the town of Dayton.
Strategy: Encourage and provide EMS skills such as IV and airway through EMS training contracts.
Barrier: Low population base and financial resources hamper recruitment attempts

Columbia County Fire District #1, an all-volunteer trauma verified BLS aid service with two units, provides service to the town of **Starbuck** and surrounding rural area in the northwestern portion of Columbia County. They provide a tiered EMS response with Columbia County BLS Ambulance.

Columbia County Fire District #3 provides volunteer trauma verified BLS aid service to the rural area north of Dayton with one unit. Dayton Fire Department, a licensed BLS aid service shares the same EMS personnel and responds with one unit. They both respond in a tiered system with Columbia County Ambulance from Dayton. The identified need for Dayton Fire Department to become a licensed trauma verified BLS aid service to respond with Columbia County Ambulance in the City of Dayton was accomplished in 2002.

Need: Trauma verified BLS aid service in the Tucannon Recreational Area, located in the eastern portion of Columbia County, to provide tiered EMS response with Columbia County BLS Ambulance. Increased numbers and acuity of EMS calls is the justification for this recommendation.
Goal: Establish an aid service in the Tucannon Area
Objective: Continue to provide EMS training through Regional EMS training contracts.
Strategy: Regional and local councils recommendations as reflected in the maximum number of BLS Aid Services for Columbia County.
Barrier: Low population base and financial resources.

Columbia County Search and Rescue, located in the town of Dayton, serves the rural area surrounding the town of Dayton with a volunteer licensed BLS aid service with one unit. They respond in a tiered EMS system with Columbia County Ambulance.

Benton County

Benton County has an area of 1,703 square miles, classified as rural suburban with urban areas located in the Cities of Richland and Kennewick.

Kennewick City Fire Department provides a paid trauma verified ALS ambulance service to the **City of Kennewick** and surrounding rural areas utilizing five units. They provide ALS rendezvous with Benton County Fire District #6 ILS ambulance.

American Medical Response (AMR), located in **Benton and Franklin Counties**, provides a private trauma verified service with paid staff and two units, specifically for ALS inter-city, interfacility, and out of the Region patient transports. They are not part of the 9-1-1 EMS response systems. The Regional maximum ALS Transport Service recommendation reflects this ALS "Interfacility" transport agency.

Richland City Fire Department provides paid trauma verified ALS ambulance to the **Cities of Richland and West Richland** and surrounding rural areas, utilizing four units. They provide ALS rendezvous with Benton County Fire District #2 BLS ambulance from Benton City.

Dyncorp Hanford Industrial Ambulance provides a private/paid trauma verified ALS ambulance service on the **Hanford Nuclear Reservation** and its boarders utilizing six units. They provide ALS rendezvous with the Grant County Fire District # 8 BLS Ambulance from Mattawa.

Benton County Fire District #1 provides paid/volunteer trauma verified BLS aid service to the rural areas surrounding the **City of Kennewick**, utilizing seven units. They provide a tiered response with the City of Kennewick Fire Department ALS Ambulances.

Benton County Fire District #2 provides a volunteer trauma verified ILS ambulance service to the town of **Benton City** and the surrounding rural areas, using two units. City of Richland Fire Department Ambulance and Prosser Memorial Hospital Ambulance provide ALS rendezvous.

Need: Trauma verified BLS aid service to provide a tiered EMS response in the rural western portion of Benton County, defined by the Benton County Fire District # 3 boundaries.
Goal: Establish an aid service in Benton County FD #3
Objective: Provide EMS training through Regional EMS training contracts.
Strategy: Regional and local councils recommendations as reflected in the maximum number of Aid Services for Benton County.
Barrier: Low population base and limited financial resources in this area.

Benton County Fire District #4 provides a volunteer trauma verified BLS aid service to the town of **West Richland** and surrounding rural areas, using three units. They provide a tiered EMS response with Richland City Fire Department ALS Ambulance and Benton County Fire District #2 BLS ambulance.

Need: Trauma verified BLS aid service to provide a tiered EMS response to the rural western portion of Benton County in the area defined by B*enton County Fire District* # *5* boundaries.
Goal: Establish an aid service in Benton County FD #5 area
Objective: Provide EMS training through Regional EMS training contracts.
Strategy: L**ocal and Regional EMS & Trauma Care Councils recommendations as reflected in the maximum number of Aid Services for Benton County.**
Barrier: Low population base and limited financial resources in this area.

Benton County Fire District #6 provides volunteer trauma verified ILS ambulance service to the community of **Paterson** and surrounding rural/wilderness area, with one ambulance and one First Responder Aid Vehicle. ALS rendezvous is provided by the City of Kennewick Fire Department Ambulance, Prosser Memorial Hospital ALS Ambulance, or ALS ambulances from the cities of Umatilla and Hermiston in Oregon.

Columbia Crest Winery Ambulance is a private industry BLS ambulance, located at St. Michelle Winery near the community of Paterson. This service provides one licensed non-trauma verified ambulance and one First Responder Aid Vehicle, staffed by winery employees who also are volunteers for Benton Co. FD #6 ILS Ambulance. They provide a tiered EMS response with Benton County Fire District #6 ILS Ambulance and have transport capabilities.

Prosser Memorial Hospital Ambulance provides trauma verified ALS ambulance service to the towns of **Prosser** and **Grandview** in Yakima County and the surrounding rural areas, utilizing paid and volunteer staff with three units. They provide ALS rendezvous with Benton County Fire District #2 BLS Ambulance from Benton City, Benton County Fire District #6 ILS Ambulance from Paterson, and Klickitat Fire District #2 BLS Ambulance from Bickleton.

Need: Trauma verified BLS aid service for the town of Prosser and surrounding rural areas to provide a tiered EMS response with Prosser Memorial Hospital Ambulance.
Goal: Licensed and verified aid service in the Prosser Fire Department area as recommended by the local and Regional Councils and reflected in the maximum number of BLS Aid Services for Benton County.
Objective: Encourage Prosser Fire Department to become licensed and verified.
Strategy: Provide on going CME and OTEP through contracts with the Mid Columbia EMS & Trauma Care Council.
Barrier: Political issues within the City of Prosser

Franklin County

Franklin County has an area of 1,242 square miles, classified as rural and suburban with an urban area in the City of Pasco.

Franklin County Public Hospital District #1 provides a volunteer trauma verified BLS ambulance service to northern Franklin County to the communities of **Connell, Basin City, Mesa**, **Merrill's Corner** and surrounding rural areas, using five units. City of Pasco ALS ambulance provides rendezvous.

Need: ILS or ALS ambulance unit for Franklin County Public Hospital District # 1.
Goal: Increase skill levels in Franklin County Public Hospital District #1 as recommended by local and Regional recommendations and reflected in maximum numbers of ILS and ALS ambulance services for Franklin County.
Objective: Provide training for ILS skill levels through EMS training contracts.
Strategy: ILS class is scheduled for fall 2003. Currently, a Paramedic resides and responds in Connell and ILS providers reside in Basin City and Merrill's Corner.
Barrier: There are limited fire protection districts in this area of North Franklin County. Franklin County FD #1 in the area is not interested in providing EMS services, thus limiting potential EMS personnel and financial resources

Franklin County Fire District #2 provides a volunteer trauma verified BLS ambulance service to the rural town of **Kahlotus** and surrounding rural areas, with one ambulance and one aid vehicle. This service has long response and transport times. The City of Pasco Fire Department ALS Ambulance provides ALS rendezvous.

Need: ILS ambulance service in Franklin County Fire District #2. (This BLS ambulance is struggling to maintain its BLS ambulance status.)
Goal: Increase EMS skill levels for Franklin County Fire District #2 as recommended by local and Regional Councils and reflected in the maximum number of recommendations for ILS ambulance services in Franklin County.
Objective: Encourage new EMS providers and increase skill levels.
Strategy 1: Promote maintaining at least BLS trauma verification level with a goal to increase to ILS level in Franklin County Fire District #2 in Kahlotus.
Strategy 2: Initial EMT training and 2003 ILS class are provided through Regional EMS training contracts.
Barrier: Low population base and financial resources.

Franklin County Fire District # 3 provides volunteer trauma verified BLS aid service to the area surrounding the **City of Pasco,** utilizing six units. They provide a tiered EMS response with Pasco Fire Department ALS ambulance.

Need: Trauma verified BLS aid services in the North Franklin County PHD #1 and Franklin County FD #2 areas to provide a tiered response with the two agencies currently responding in those areas.
Goal: Establish aid services in these two areas to assist the ambulances servicing these areas as recommended in the local and Regional Councils and reflected in the maximum numbers of BLS aid services in Franklin County.

Objective: Continue to provide EMS training through Regional EMS training contracts.
Barrier: Low population base and financial resources.

Pasco Fire Department provides a paid trauma verified ALS ambulance service to the **City of Pasco** and all of **Franklin County,** utilizing four units. They are the only ALS ambulance service in Franklin County and provide ALS rendezvous with Franklin County Public Hospital District #1 BLS Ambulances, Franklin County Fire District #2 BLS Ambulance, and Walla Walla County Fire District #5 BLS ambulance.

American Medical Response (AMR) provides a private ALS ambulance service to **Benton and Franklin Counties**, with paid staff and two units specifically for ALS inter-city, interfacility, and out of the Region patient transports. They are not part of the 9-1-1 EMS response systems. The Regional maximum ALS Transport Service recommendation reflects this ALS "Interfacility" transport agency.

Kittitas County

Kittitas County has 2,297 square miles and is classified as rural with one suburban/urban area, the City of Ellensburg. Most Kittitas County communities are located along the Interstate 90 Highway corridor that runs from east to west through the county. This busy Interstate can greatly impact EMS response due to the thousands of motor vehicles that travel this roadway each day. Another impact to Kittitas County's EMS system is the large, year-round influx of non- resident recreational population.

Kittitas County Fire District #2, a volunteer/paid trauma verified BLS aid service for rural Kittitas County surrounding the City of Ellensburg, utilizing two units. They provide a tiered response with the Ellensburg Fire Department ALS Ambulance to Kittitas Co. Fire District #2 service area and surrounding state highways and Interstate 90.

Ellensburg Fire Department ALS Ambulance is a paid/volunteer department that provides service in the **City of Ellensburg** and surrounding rural areas of Kittitas Public Hospital District #1, utilizing three trauma verified ALS Ambulances and 2 First Response units. They provide a tiered response with the Kittitas Fire Department trauma verified BLS Ambulance, Kittitas County Fire District #2 and Kittitas Fire District #4 trauma verified BLS aid services.

Kittitas Fire Department, volunteer trauma verified BLS ambulance/aid services provide response in the **City of Kittitas** utilizing two units. They provide a tiered response with the Ellensburg Fire Department ALS Ambulance. Their service area includes sections of Kittitas Co. FD #2, Interstate 82, and Interstate 90.

Need: Trauma verified BLS aid service in the rural Community of Thorp as defined by Kittitas Co. FD #1's service area to provide tiered response with the Ellensburg Fire Department ALS Ambulance.
Goal: Establish a verified aid service in Kittitas Co. FD #1 as recommended by

the local and Regional Councils and reflected in the maximum numbers of BLS Aid Services in Kittitas County.
Objective: Provide EMS training through Regional EMS training contracts.
Barriers: Recruitment attempts are hampered by economics and low population base

Kittitas County Fire District #4, in the community of **Vantage,** provides a volunteer trauma verified BLS aid service with one unit. They provide a tiered response with the Ellensburg Fire Department ALS Ambulance and mutual aid upon request with Grant County Fire District # 8 BLS Ambulance from Mattawa.

Kittitas County Public Hospital District #2 provides a paid ALS ambulance service to the **City of Cle Elum** and surrounding rural/wilderness areas of Kittitas Hospital District #2, utilizing one ALS ambulance and one BLS ambulance. They provide tiered response with Cle Elum Fire Department BLS trauma verified ambulance, Kittitas County Fire District #3, and Kittitas County Fire District #8 aid services. They also provide ALS tiered response with Roslyn Fire Department and Cle Elum Fire Department BLS Ambulances.

Cle Elum Fire Department provides volunteer trauma verified BLS aid/ambulance service to the **City of Cle Elum**, utilizing one ambulance and two aid units. They respond in a tiered response with Kittitas PHD #2 ALS Ambulance. They provide mutual aid response to South Cle Elum, and other surrounding areas of Kittitas County Public Hospital District #2 when requested.

South Cle Elum Fire Department provides trauma verified BLS aid service to the community of **South Cle Elum**. Ambulance response to South Cle Elum can be delayed due to access barriers of increased railroad traffic and the natural barrier of the Yakima River. They will also provide a tiered response with Cle Elum Fire Department BLS ambulance/aid and Kittitas County PHD #2 ALS Ambulance

Roslyn Fire Department provides volunteer trauma verified BLS ambulance to the Town of **Roslyn** utilizing one ambulance. Kittitas PHD #2 ALS Ambulance provides tiered ALS response from Cle Elum.

Kittitas County Fire District #3 in the community of **Easton** and surrounding rural/wilderness areas provides volunteer trauma verified BLS aid service utilizing one unit. They provide tiered response with Kittitas County PHD #2 ALS ambulance to their service area and additional sections of Interstate 90.

Trauma verified BLS aid service to the Lake Cle Elum area designated by Kittitas County FD #6 are provided by volunteers through Kittitas County PHD #2. This service provides a tiered response with Kittitas PHD #2 ALS Ambulance.

Need: Trauma verified BLS aid service in the Teanaway area defined by Kittitas Co. FD #7's service area to provide tiered response with Kittitas County PHD #2 ALS Ambulance.
Goal: Establish an aid service in Kittitas Co. FD #7 as recommended by the

local and Regional Councils and reflected in the maximum numbers for BLS services in Kittitas County.
Objective: Provide EMS training through Regional EMS training contracts.
Barriers: Recruitment attempts are hampered by economics and low population base

Kittitas County Fire District #8, a volunteer trauma verified BLS aid service, provides response to the community of **Lake Kachess** and surrounding rural/wilderness area, utilizing one unit. They provide a tiered response with Kittitas County PHD #2 ALS Ambulance to their service area, the recreational areas of Lake Kachess and sections of Interstate 90.

King County Fire District #51, located on the summit of **Snoqualmie Pass,** provides volunteer trauma verified BLS Ambulance/aid service with two units. They provide automatic aid response with Kittitas PHD @2 ALS Ambulance from milepost 52.5 to milepost 63.5.

Walla Walla County

Walla Walla County, 1,270 square miles, is classified as rural with one suburban/urban center in the City of Walla Walla.

The City of Walla Walla Fire Department Ambulance provides a trauma verified ALS ambulance service for the **City of Walla Walla** and all of **Walla Walla County**, utilizing paid staff and five units. They provide ALS ambulance rendezvous with Waitsburg BLS ambulance, Walla Walla Fire District #5 BLS ambulance, Columbia County BLS Ambulance and Milton Freewater Rural Rescue BLS Ambulance in Oregon.

College Place Fire Department provides a volunteer trauma verified BLS aid service for the town of **College Place** and surrounding rural area, with three units. They provide a tiered response with the City of Walla Walla Fire Department ALS Ambulance.

Walla Walla County Fire District #1 provides a trauma verified BLS aid service for the community of **Clyde** and surrounding rural area**,** utilizing volunteers and one unit. They provide a tiered EMS response with the City of Walla Walla Fire Department ALS Ambulance and Walla Walla Fire District #5 BLS Ambulance.

Need: Increased EMS personnel for Walla Walla County FD # 1
Goal: Additional EMS providers in Walla Walla County FD #1
Objective: Encourage initial training for additional EMS providers through Regional EMS training contracts.
Barrier: Recruitment attempts are hampered by economics and low population base.

Waitsburg Ambulance provides a private non-profit trauma verified BLS ambulance service for the town of **Waitsburg** and surrounding rural areas, defined by Walla Walla County Fire District #2 boundaries. They utilize volunteers and two units.

The City of Walla Walla Fire Department Ambulance provides ALS rendezvous.

Need: Trauma verified BLS aid service in Walla Walla County Fire District #2 to respond in a tiered EMS system with Waitsburg BLS Ambulance and Walla Walla City County ALS Ambulance.
Goal: Establish an aid service in Walla Walla County FD #2 as recommended by the local and Regional Councils and reflected in the maximum BLS Aid Services for Walla Walla County.
Objective: Provide EMS training through Regional EMS training contracts.
Barrier: Recruitment attempts are hampered by economics and low population base.

Walla Walla County Fire District #3 provides a volunteer trauma verified BLS aid service to the community of **Eureka** and surrounding rural areas, utilizing one unit. They provide a tiered EMS response with the City of Walla Walla Fire Department ALS Ambulance.

Need: Increased EMS personnel for Walla Walla County Fire District # 3
Goal: Additional EMS providers in Walla Walla County FD #3.
Objective: Continue to provide EMS training through Regional EMS training contracts.
Strategy: Monitor number of new EMS providers for Walla Walla Fire District #3
Barrier: Recruitment attempts are hampered by economics and low population base.

Walla Walla County Fire District #4 provides a volunteer trauma verified BLS ambulance in the City of **Walla Walla** and the surrounding rural areas. They have an ambulance unit and four-wheel vehicles utilized as aid units. They provide a tiered/backup EMS response with the City of Walla Walla Fire Department ALS Ambulance. * Even though WWCFD #4 is licensed and verified as a BLS ambulance, they frequently respond only as a BLS aid vehicle. The maximum number of "BLS Aid" reflects this agency when it responds as an Aid Services.

Walla Walla County Fire District #5 provides a trauma verified BLS ambulance service in western **Walla Walla County** and in the community of **Burbank** and surrounding rural area, utilizing volunteer staff and two units. Pasco Fire Department ALS Ambulance or the City of Walla Walla Fire Department ALS Ambulance provide ALS ambulance rendezvous depending on the location of the incident. This service is closer to the Tri-Cities; therefore, the majority of patients are transported to the Tri Cities Trauma Service facilities.

Need: Trauma verified ILS ambulance service in Walla Walla County FD #5 to provide a tiered EMS system with ALS ambulances from Pasco and the City of Walla Walla.
Goal: Increase EMS skill levels at Walla Walla Fire District #5.
Objective: Encourage the local Council to provide CME and OTEP including IV training for this agency.

Strategy: Encourage EMS levels recommended by the Local and Regional Councils and reflected in the maximum numbers for ILS Ambulance
Barrier: Recruitment attempts are hampered by economics and low population base.

Walla Walla County Fire District #6 provides a volunteer trauma verified BLS aid service to the communities of **Touchet** and **Lowden** and surrounding rural areas, utilizing one unit. They provide a tiered EMS response with Walla Walla Fire District #5 BLS Ambulance and the City of Walla Walla Fire Department ALS Ambulance.

Walla Walla County Fire District #7 provides a volunteer trauma verified BLS aid service to the community of **Prescott** and surrounding rural area, with two units. They provide a tiered EMS response with Waitsburg BLS Ambulance and the City of Walla Walla Fire Department ALS Ambulance.

Need: Increased EMS personnel for Walla Walla County Fire District # 7
Goal: Additional EMS providers for Walla Walla FD #7.
Objective: Provide EMS training through Regional EMS training contracts with Walla Walla County EMS & Trauma Care Council.
Strategy: Monitor number of new EMS providers for Walla Walla Fire District #7
Barrier: Recruitment attempts are hampered by economics and low population base.

Walla Walla County Fire District #8 provides a volunteer trauma verified BLS aid service to the community of **Dixie** and surrounding rural areas, utilizing two units. They respond in a tiered EMS response with Walla Walla City County ALS Ambulance.

Yakima County

Yakima is the largest county in the Region with 4,296 square miles. It is classified as wilderness, rural, suburban, and urban, the City of Yakima.

Tieton Fire Department provides volunteer trauma verified BLS aid service to the town of **Tieton** and surrounding rural/wilderness areas utilizing two units. They provide a tiered EMS response with the two ALS ambulance services from the City of Yakima.

Yakima County Fire District # 1 provides volunteer trauma verified BLS aid service to the community of **Cowiche** and surrounding rural/wilderness areas, utilizing two units. This service experiences long response and transport time. They provide a tiered EMS response with the two ALS ambulance services from the City of Yakima.

Need: Trauma verified BLS ambulance service for Yakima County Fire District # 1 to provide rendezvous with ALS ambulances from the City of Yakima.

Goal: Increased EMS skill levels for Yakima Co. FD #1 as recommended by the Local and Regional Councils as reflected in the maximum numbers for BLS Ambulance Services for Yakima County.
Objective: Provide EMS training through Regional EMS training contracts with Yakima County EMS & Trauma Care Council.
Barriers: Economics and low population base.

Yakima County Fire District #2 provides a volunteer trauma verified BLS aid service to the town of **Selah,** surrounding rural/wilderness areas of Yakima River Canyon, the Wenas Valley, the Lt. Murray Recreational Area and a portion of Interstate-82 between Yakima and Ellensburg, using six units. They provide a tiered EMS response with the two ALS ambulance services from the City of Yakima.

Yakima County Fire District #3 provides a volunteer trauma verified BLS aid service to the town of **Naches** and the surrounding rural areas including State Route 12 and the White Pass Highway, utilizing three units. Both ALS ambulance response and transport times from this agencies service areas exceed 30 minutes. They provide a tiered EMS response with the 2 ALS ambulance services from the City of Yakima.

Need: Trauma verified BLS ambulance service for Yakima County Fire District # 3 to provide rendezvous with ALS ambulances from the City of Yakima
Goal: Increased EMS levels for Yakima County FD #3 as recommended by the local and Regional Councils and reflected in the maximum numbers for BLS Ambulance Services for Yakima County.
Objective: Provide EMS training through Regional EMS training contracts
Strategies: Yakima County Fire District #3 currently has a vehicle that is transport capable and the Yakima MPD has a protocol that allows for transport to ALS rendezvous if needed.
Barriers: Economics and low population base.

Yakima County Fire District #4 provides a volunteer trauma verified BLS aid service to the communities of **Terrace Heights** and **Moxee** and surrounding rural areas, utilizing three units. They provide a tiered EMS response with the two ALS ambulance services from the City of Yakima.

Yakima Fire District #5 provides a volunteer/paid trauma verified BLS aid service to **700** square miles of the Lower Yakima Valley and the Yakama Indian Reservation. This agency shares personnel and EMS units with six cities. They provide ten additional stations and utilize twenty-eight units.

Station #1, **White Swan;** Station # 2, **Brownstown;** and Station #3, **Harrah,** provide a tiered response with ILS White Swan Ambulance and ALS ambulances from Toppenish and the City of Yakima.

(^ Indicates shared personnel and EMS units with city fire departments. The city fire departments respond within their city limits and Yakima Fire District # 5 responds to surrounding rural areas.)

Station # 4, **Gamache;** Station # 5, **Parker;** ^Station # 6, **Wapato;** Station # 7, **Sawyer;** Station # 8, **Buena;** ^Station # 9, **Toppenish;** and ^Station #10, **Zillah;** ^Station # 11, **Granger;** and Station # 16, **Satus** provide tiered EMS response with the ALS ambulances from Toppenish and the City of Yakima.

Station # 12, **Outlook** and ^Station #13, **Sunnyside** provides tiered EMS response with ***ALS*** Sunnyside Ambulance.

^Station # 14, **Grandview** and ^Station # 15, **Mabton**; provide tiered EMS response with Prosser Memorial Hospital ALS Ambulance from the City of Prosser in Benton County and Sunnyside Fire Department ALS Ambulance.

To be able to provide adequate EMS volunteer staff to this large service area the following stations respond jointly:

1. Station # 1, **White Swan**; Station # 2, **Brownstown**; and Station # 3, **Harrah**;
2. Station # 7, **Sawyer**; and Station # 8, **Buena**
3. Station # 16, **Satus**; Station # 11, **Granger**; and Station # 9, **Toppinish.**

Need: At least one ILS aid unit for Yakima County Fire District #5 BLS trauma verified aid service.
Goal: Increased EMS skills levels for Yakima Co. FD #5 as recommended by the local and Regional Councils and reflected in the maximum numbers for ILS in Yakima County.
Objective: Provided initial ILS training and EMS training through Regional EMS training contracts
Barrier: Economics and low population base.

Need: Trauma verified BLS ambulance service in Yakima County Fire District # 5 shared stations in Zillah, Toppenish, Wapato, and Mabton to provide rendezvous with ALS ambulances. Many locations within Yakima Fire District #5 service area have long response and transport times.
Goal: Increased EMS service levels in Yakima Co. FD #5 area as recommended by the local and Regional Councils and reflected in the maximum numbers for BLS Ambulance Services for Yakima County.
Objective: Provide EMS training through Regional EMS training contracts
Strategies: Yakima County Fire District #5 currently has vehicles that are transport capable and the Yakima MPD has a protocol in place so that they can provide transport to ALS rendezvous if needed.
Barrier: Economics and low population base.

Yakima County Fire District #6 provides a volunteer trauma verified BLS aid service to the community of **Gleed** and surrounding rural area, utilizing two units. They provide a tiered EMS response with the two ALS ambulance services from the City of Yakima.

Need: Trauma verified BLS aid service for the rural area in Yakima County

area between the towns of Mabton and Bickleton as defined in the boundaries of *Yakima County Fire District # 7* to provide a tiered EMS response with the ambulance services from Bickleton, Sunnyside, Prosser and Toppenish.
Goal: Establish an aid service in the Yakima Co. FD #7 area as recommended by the local and Regional Councils and reflected in the maximum number of BLS Aid Services for Yakima County.
Objective: Continue to provide EMS training through Regional EMS training contracts with Yakima County EMS & Trauma Care Council.
Barriers: Recruitment attempts are hampered by economics and low population base

Yakima County Fire District #9 provides a volunteer trauma verified BLS aid service to the community of **Naches Heights** and surrounding rural area, utilizing four units. They provide a tiered EMS response with the two ALS ambulance services from the City of Yakima.

Yakima County Fire District #12 provides a paid/volunteer trauma verified BLS aid service to the communities of **West Valley** and **Tampico** and surrounding rural/wilderness areas, utilizing five units. This service has long response times and long ambulance response and transport times often exceed 30 minutes. They provide a tiered EMS response with the two ALS ambulance services from the City of Yakima.

Need: BLS ambulance service for Yakima County Fire District # 12 to provide rendezvous with ALS ambulances from the City of Yakima.
Goal: Increased EMS levels in Yakima Co. FD #12 area as recommended by local and Regional Councils and reflected in the maximum recommendation for BLS Ambulance Services for Yakima County.
Objective: Provide EMS training through Regional EMS training contracts
Strategies: When necessary, utilize Yakima County Fire District #12's vehicle that is transport capable. The Yakima MPD has a protocol that allows for transport to ALS rendezvous if needed.
Barriers: Economics and low population base.

Yakima County Fire District #14 provides a volunteer trauma verified BLS aid service to the communities of **Nile Valley, Cliffdale,** Highway 410, Chinook Pass**,** and surrounding rural/wilderness areas, utilizing one unit. This service has long response times and ambulance response to this area often exceeds 30 minutes. In addition this area experiences a large influx of non-resident year-round recreational population. Yakima Fire District #14 provides a tiered EMS response with the two ALS ambulance services from the City of Yakima.

Need: ILS or BLS trauma verified ambulance service for Yakima County Fire District #14 in Nile/Cliffdale area to rendezvous with the ALS ambulances from the City of Yakima.
Goal: Increased EMS levels in the Yakima Co. FD #14 area as recommended by local and Regional Councils and reflected in the maximum recommendation for BLS and ILS Ambulance Services for Yakima County.

Objective: Continue to provide EMS training through Regional EMS training contracts
Strategies: Continue to utilize Yakima County Fire District #14's vehicle that is transport capable when needed. The Yakima MPD has a protocol that allows for transport to ALS rendezvous if needed.
Barriers: Economics and low population base.

Yakima City Fire Department provides a paid/volunteer trauma verified BLS aid service to the **City of Yakima,** classified as urban/suburban**,** with ten units. They provide a tiered EMS response with the two ALS ambulance services located in the City of Yakima.

In the City of Yakima and surrounding suburban, rural` and wilderness areas, trauma verified ALS ambulance service is provided by two ambulance services.

American Medical Response, a private ambulance service, has three ALS units stationed in the City of Yakima, one ALS unit stationed in the City of Union Gap and one unit stationed in the City of Toppenish. AMR provides ALS ambulance response in a tiered EMS system with Fire Districts # 1, 2, 3, 4, 6, 9, 12, 14, Union Gap Fire Department, and the City of Yakima aid services. From their Toppenish station they provide a tiered EMS response with aid services from Yakima Fire District #5, Toppenish Fire Department, Wapato Fire Department, and Zillah Fire & Rescue.

Advanced Life Systems, a private ambulance service with four units stationed in the City of Yakima, provides ALS ambulance response to the City of Yakima and tiered responses with Fire Districts # 1, #2, #3, #4, #6, #9, #12, #14, Union Gap Fire Department, and the City of Yakima aid services.

Union Gap Fire Department provides trauma verified BLS aid service in the urban/suburban **City of Union Gap** and surrounding rural area, utilizing paid/volunteer staff and four units. They provide a tiered EMS response with the two ALS ambulance services from City of Yakima.

Zillah City Fire & Rescue provides trauma verified BLS aid service to the town of Zillah and surrounding rural areas*,* utilizing volunteers and three units. They provide a tiered EMS response with the ALS Ambulances from Toppenish and the City of Yakima and Sunnyside Fire Department ALS Ambulance.

White Swan Ambulance provides a tribally owned trauma verified ILS ambulance service to the community of **White Swan** and surrounding rural/wilderness areas on the Yakama Reservation, utilizing volunteers and three units. Ambulances provide ALS ambulance rendezvous from Toppenish and the City of Yakima

Wapato Fire Department provides a trauma verified BLS aid service to the town of **Wapato** and surrounding rural areas, with volunteer with two units. They provide a tiered EMS response with ALS ambulance services from Toppenish and the City of Yakima.

Toppenish Fire Department provides a trauma verified BLS aid service to the town of **Toppenish** and surrounding rural areas, with volunteer and two units. They provide a tiered EMS response with the ALS ambulance from Toppenish and the City of Yakima.

Granger Fire Department provides a trauma verified BLS aid service to the town of **Granger** and surrounding rural areas, with volunteers and two units. They provide a tiered EMS response with the Toppenish and Sunnyside ALS ambulances.

Sunnyside Fire Department provides a paid/volunteer trauma verified ALS ambulance service to the **City of Sunnyside** and surrounding rural areas, utilizing three units. They provide ALS rendezvous for BLS ambulances from Grant County Fire District #10 in Mattawa and Klickitat County Fire District #2 in Bickleton.

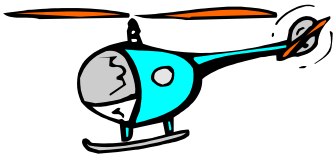
Mabton Fire Department provides a volunteer trauma verified BLS aid service to the town of **Mabton** and surrounding rural areas, with two units. They provide a tiered EMS response with Sunnyside Fire Department ALS Ambulance and Prosser Memorial ALS Ambulance.

Grandview Fire Department provides a trauma verified BLS aid service to the town of **Grandview** and surrounding rural areas, utilizing volunteers with two units. They provide a tiered EMS response with Sunnyside Fire Department and Prosser Memorial Hospital Ambulance ALS services.

Prosser Memorial Hospital Ambulance in the City of **Prosser**, located in Benton County, provides trauma verified ALS ambulance tiered response with aid services from Grandview and Mabton Fire Departments. They also provide ALS rendezvous with Klickitat Fire District #2 BLS Ambulance from Bickleton.

Klickitat County Fire District #2, provides volunteer trauma verified BLS ambulance service to the community of **Bickleton** and surrounding remote wilderness areas of northern Klickitat County, utilizing two units. This is an "out of Region EMS agency" that routinely transports patients to South Central Region trauma services in Sunnyside and Prosser. Benton County Fire District #6 ILS Ambulance provides rendezvous from Paterson, Prosser Memorial Hospital ALS Ambulance and Sunnyside Fire Department ALS Ambulance

Grant County Fire District #8 provides a volunteer trauma verified BLS ambulances service to the rural communities of **Mattawa** and **Desert Air** and surrounding rural/wilderness areas of southern Grant County, utilizing two units. This is an additional "out of the Region EMS agency" that routinely transport patients to South Central Region trauma services in Yakima, Sunnyside, and Richland. Ambulances from the City of Yakima, Dynacorp Hanford Industrial Ambulance, Richland Fire Department and Sunnyside Fire Department provide ALS ambulance rendezvous for this agency.
Each local EMS & trauma care councils have provided county maps showing EMS service boundaries.



Air Ambulance Services

The Regional Council recognized early in trauma system development that emergency medical helicopter ambulance scene response would greatly enhance EMS and trauma care within the Region. A centrally located emergency medical helicopter ambulance would help to reduce long response and transport times. In 2002 emergency medical helicopter service from a location outside of the Region became available. In January 2003 an emergency medical helicopter service was located in the Region at the Pasco airport.

ALS interfacility transport fixed wing air ambulance service no longer available within the Region. Services respond to the South Central Region from Seattle, Spokane, and Wenatchee. When the MAST helicopter is available at the Yakima Training Center, they provide wilderness emergency rescue. DOH is in the process of developing a statewide air ambulance plan. The following are the Air Ambulance Resources in the Region:

- *Northwest MedStar* provides ALS on scene air ambulance helicopter service from the Pasco Airport and fixed wing interfacility air ambulance service from Spokane in the East Region.
- *Airlift Northwest* provides ALS air ambulance helicopter scene response from the Seattle area and interfacility fixed wing air ambulance service from both Seattle in the Central Region and Wenatchee in the North Central Region.
- The U.S. Army MAST Helicopter Unit from the Yakima Training Center provides emergency helicopter rescues for remote wilderness incidents in Yakima and Kittitas Counties.

2. Issues, Needs and Weakness

An identified weakness of the EMS & Trauma System is the decline of rural volunteer EMS providers. The goal to encourage and promote initial EMS training especially in the rural areas where volunteers are declining is discussed in the Prehospital EMS & Trauma Verified Services Goals above.

3. Regional Verified Aid and Ambulance Goals

Goal: Verified Trauma Care Services meet trauma patient care needs within each county and across the region.

Objective 1: Support the process for identification of EMS needs and distribution through annual regional planning meetings with the local councils.

Strategy 1: Assist local councils with planning for minimum and maximum numbers of trauma verified EMS agencies that meet the legislative mandate to avoid inefficient duplication of EMS services.

Strategy 2: Provide technical assistance to local councils as needed to develop justification documentation for any recommended changes to minimum or maximum numbers of trauma

verified EMS services.
Strategy 3: Continue to provide annual funding to support training to retain and attract EMS volunteers.
Objective 2: During the biennium, establish a three-tiered EMS system of verified trauma service response to potential major trauma.
Strategy 1: Utilize the Regional Council's prehospital committee to identify the current status, what is needed for the three-tiered system and the steps to be taken in the region in 2003-04 and 2004-05.
Strategy 2: Enlist broad representation of local county stakeholders in the regional planning process in 2003-04 and 2004-05.

Goal: More EMS volunteers throughout rural areas of the region.
Objective 1: Encourage and promote new EMS volunteers through annual grants for training.
Strategy 1: Provide initial EMT B courses throughout the Region through EMS training contracts with the local EMS & Trauma Care Councils
Strategy 2: Continuing Medical Education and Ongoing Training Education program funding through established EMS training contracts with the local EMS & trauma care councils.
Projected Costs: It is difficult to identity how many additional classes would be necessary. It is not cost effective to offer an EMT course to 3 to 5 people.
Barrier: Minimal training funds and decreasing volunteer interest

4. Table B: Recommended Minimum and Maximum Numbers for EMS Verified Trauma Services

Benton County

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	4	4	2	4	4
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	2	2	0	2	2
Amb - ILS	0	2	2	2	2
Amb - ALS	4	5	5	4	5

American Medical Response (AMR) provides a private ALS ambulance service to **Benton and Franklin Counties**, with paid staff and two units specifically for ALS inter-city, interfacility and out of region trauma verified ambulance. They are not part of the 9-1-1 EMS response systems. The Regional maximum ALS Transport Service recommendation reflects this ALS "Interfacility" transport agency.

Columbia County

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	2	3	2	2	4
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	1	1	1	1	1
Amb - ILS	0	0	0	0	1
Amb - ALS	0	0	0	0	0

The Regional Council recommends an increase in EMS skill and trauma verification levels to either ILS* or ALS ambulance for Columbia County Ambulance. If Columbia County Ambulance moves to either ILS or ALS, the minimum and maximum numbers for BLS ambulance would change to 0.

Franklin County

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	1	3	1	1	3
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	2	2	2	2	2
Amb - ILS	0	2	0	0	2
Amb - ALS	2	2	2	2	2

Franklin County Fire District #2 is recommended to become ILS ambulance services. Franklin County PHD #1 is recommended to increase to at least one ILS/ALS ambulance. If Franklin County FD #2 or all of Franklin County PHD #1 increase to ILS ambulance, the recommended minimum numbers for BLS ambulances would decrease accordingly.

American Medical Response (AMR) provides a private ALS ambulance service to **Benton and Franklin Counties**, with paid staff and two units specifically for ALS inter-city, interfacility, and out of the Region patient transports. They are not part of the 9-1-1 EMS response systems. The Regional minimum and maximum ALS Transport Service recommendation reflects this ALS "Interfacility" transport agency.

Kittitas County

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	5	10	5	5	10
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	1	3	3	1	3
Amb - ILS	0	0	0	0	0
Amb - ALS	2	2	2	2	2

Walla Walla County

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	8	8	6	8	8
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb-BLS	2	3	3	2	3
Amb - ILS	0	1	0	1	0
Amb - ALS	1	1	1	1	1

A BLS trauma verified aid service in the area identified by Walla Walla County FD #2 boundaries is identified as a need and is reflected in the minimum and maximum numbers.

Walla Walla County Fire District #5 Trauma Verified BLS Ambulance has long been recommended to increase their level of service to trauma verified ILS ambulance. If they should move to ILS ambulance, the recommended minimum and maximum numbers for BLS ambulance would change to 2.

Yakima County

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	18	20	18	18	20
Aid - ILS	0	1	0	0	1
Aid - ALS	0	0	0	0	0

Amb-BLS	**2**	**9**	**0**	**1**	**8**
Amb - ILS	**0**	**1**	**1**	**0**	**1**
Amb - ALS	**3**	**3**	**3**	**3**	**3**

A BLS trauma verified aid service, in the area identified by the boundaries of Yakima Co. Fire District #7, is identified as a need and is reflected in the minimum and maximum numbers.

Yakima County Fire District #5 BLS aid service is recommended to increase skill levels to include at least one ILS aid unit. If all of Yakima FD #5 moves to ILS the maximum number of recommended BLS aid services would change to 19.

E. PATIENT CARE PROCEDURES (PCPs)

PCPs are defined in WAC as "written operating guidelines adopted by regional councils in consultation with local EMS & trauma care councils, MPDs, and emergency dispatch centers." Regional PCPs are the foundation for county operating procedures (COPS) and the broad base for local patient care protocols. MPD protocols cannot be in conflict with Regional PCPs. A number of these local COPS have been submitted with the Regional PCPs for DOH review.

1. Current Status

The Regional Council has developed and put into place the following PCPs to provide direction and guidance for trauma system implementation:

Patient Care Procedure # 1 - Dispatch
Patient Care Procedure # 2 - Response Times
Patient Care Procedure # 3 - Triage And Transport
Patient Care Procedure # 4 - Interfacility Transfer
Patient Care Procedure # 5 - Medical Command at Scene
Patient Care Procedure # 6 - EMS/Medical Control Communications
Patient Care Procedure # 7 - Helicopter Alert and Response
Patient Care Procedure # 8 - Diversion
Patient Care Procedure # 9 - BLS/ILS Ambulance Rendezvous with ALS Ambulance
Patient Care Procedure #10 -Trauma System Data Collection
Patient Care Procedure #11 -Routine EMS Response Outside of Recognized Service Coverage Area
Patient Care Procedure #12 -Emergency Preparedness/ Special Responders

Changes have been made to Patient Care Procedure #3, "Triage and Transport" and Patient Care Procedure #8 "Diversion" to expand and further clarify specific patient conditions that would over-ride the decision to divert.

County Operating Procedures in several counties are being revised to meet the need for COPs for Emergency Medical Helicopter procedures now that Northwest MedStar has established a helicopter within the South Central Region. Those COPs will be forwarded to DOH as they are submitted to the Regional Council.

2. Issues, Needs and Weaknesses

Regional Patient Care Procedures (PCPs) are a Trauma System success in the South Central Region. Remaining needs are to improve and streamline them in order to continually improve patient care. Regional PCPs have been implemented by all EMS agencies in all counties and updated to reflect the needs of the Region. Emergency Dispatch Centers, who have no obligation to follow Regional PCPs, are using PCP # 1, Dispatch. Additionally, County Operating Procedures (COPS) have been developed in five of the six counties to provide more specific local direction for Regional PCPs.

Regional PCPs and local COPs provide an organized approach to care of trauma and medical patients in the field. Through the State Trauma Triage Tool, Regional PCPs, and COPS, EMS agencies know where to transport both trauma and medical patients (PCP # 9 includes a prearranged process for BLS and ILS agencies when a rendezvous with ALS agencies are needed.) The region has not identified the need for additional PCPs.

3. PCP and COP Goals

Goal: Patient Care Procedures and County Operating Procedures that meet the needs for excellent patient care in the South Central Region.
Objective1: By June 30, 2005 the Regional PCP Committee will review and revise, as needed the Patient Care Procedures.
Strategy: The Regional PCP Committee will seek input from local EMS & Trauma Care Councils and MPDs annually and will utilize the input to develop recommendations for PCP changes.
Objective 2: The Regional Council will direct the PCP Committee to draft new PCPs during the biennium as needed for system change.
Strategy 1: The Regional PCP Committee will seek input from the local councils in developing draft PCPs
Strategy 2: The Regional Council will seek DOH approval prior to implementing new PCPs
Objective 3: Local EMS & Trauma Care Councils will develop and submit COPS to the Regional Council.
Strategy: The Regional Council will provide technical assistance to the local councils as needed for COP development to ensure COPs are consistent with Regional PCPs.
Projected Costs: It is difficult to place a monetary figure on the cost of time for MPDs and Regional Council members.
Barrier: Lack of input from MPDs and some local EMS & Trauma Care Councils

F. Multi County or County/Inter Regional Prehospital Care

1. Issues, Needs and Weaknesses

The common link between counties is disaster and mutual aid. Each county is required by Revised Codes of Washington (RCW) and Washington Administrative Code (WAC) to have a mass casualty disaster plan developed by the county's Emergency Management Division. County disaster plans address mass casualty incidents that include EMS, emergency communication, and trauma services resources.

The Regional Council utilizes the local EMS & Trauma Care Councils to review county disaster plan to assure that current EMS and trauma services are included and up to date. All county disaster plans were found to include disaster mutual aid agreements which detail how the counties will interface with neighboring counties during a disaster. The disaster plan review process uncovered

two multi-county issues. It showed that not all counties hold disaster drills with neighboring counties. It also disclosed the communication equipment incompatibilities between agencies (EMS and other agencies) as noted in the Communications section of the prehospital section of the Regional EMS and Trauma System Plan.

2. Multi County or County/Inter Regional Prehospital Care Goals
Goal: Disaster drills that are Regional in scope.
Objective: Encourage and promote all EMS agencies and verified trauma care services to participate in a Regional drill by the end of the biennium.
Strategy 1: Facilitate the development of a working committee to look into the feasibility of a Regional drill in 2004
Strategy 2: Participate in coordination of a Regional disaster drill by 2005.
Projected Costs: It is difficult to identify the cost of personnel time for involvement in a disaster drill.
Barrier: Logistics and cost of such a drill.

V. DESIGNATED TRAUMA CARE SERVICES

Trauma Services are integral parts of the EMS and Trauma Care System. They provide the definitive initial and prolonged care to trauma patients. Their readiness and resources are vital. The comprehensive EMS and Trauma Care System in the State of Washington includes the designation of trauma services. Designation is an elective procedure. Health care facilities that participate make a commitment and choose to do so. Each health care facility determines the level of trauma service designation to seek and completes the designation application process. Each facility must have a team approach with a trauma team activation plan, trauma education, trauma registry data submission, and an on going continuous quality improvement (CQI) program.

The South Central Regional Council recommends to DOH, the number, level and location of trauma services. Designation recommendations are based on the analysis of population data, numbers of patients meeting trauma criteria, locations of health care facilities, existing EMS transport patterns and estimated EMS transport times. The Regional Council conducted surveys of Regional health care facilities that supplied data on surgical and medical resources available at each facility. Regional analysis showed a broad spectrum of trauma care and medical staff capabilities, ranging from small rural clinics and hospitals with limited medical resources to large medical centers with sophisticated trauma care equipment and medical specialties. As with EMS resources, higher-level trauma designation and trauma care resources are available in suburban/urban areas. The Regional Council recommended three Level II Trauma Services within the Region based on the long distances and transport times between health care facilities. No changes to the minimum or maximum numbers of general, pediatric or rehabilitation trauma services are recommended this biennium.

A. Issues, Needs and Weaknesses

Several system issues affect trauma service resources in the South Central Region. All health care facilities within the Region have been designated as trauma services. However, several hospitals have sought designation below the levels recommended by the Regional Council for adequate trauma service distribution. This includes the following areas:

In the City of Yakima and the Tri Cities (Richland, Kennewick, Pasco), the hospitals designated as Level III when the Regional Council recommended Level IIs in those cities.

In the Cities of Ellensburg and Toppenish, the hospitals have designated as Level IVs rather than the Level IIIs as recommended by the Regional Council

In the City of Dayton, the hospital designated as a Level V rather than the Level IV recommended by the Regional Council.

Neurosurgical coverage at trauma services that provide those services has been an issue within the Region. Neurosurgical physician coverage is not always available twenty-four hours a day, seven days a week. EMS agencies transporting trauma related to head injury must check to see if neurosurgical services are available. This issue has been identified through the regional system CQI process and is being addressed by trauma centers with the assistance of the Department of Health Office of EMS & Trauma. The Regional Council continues to monitor EMS transport issues related to this issue and its effect on the Regional system.

Hospital personnel shortages, particularly nursing shortages, affect staffing resources. The South Central Region is experiencing the same nursing shortage that is plaguing the nation. The Region's schools of nursing in Yakima, Pasco, and Walla Walla, graduate new nurses every year. However, due to the fact that many new nurses leave the Region for more urban population centers where pay is higher and more specialized positions are available, nursing shortages continue. Many health care facilities within the Region utilize "traveling nurse services" to make up for the shortage of nurses. Use of these services increases nursing care cost for facilities.

Sunnyside Community Hospital and Lourdes Medical Center have taken a different approach to address the nursing shortage and will be importing foreign trained registered nurses to help cover their shortages. Sunnyside Community Hospital also is becoming a training center for Osteopathic Physicians. They have signed agreements with the University of Health Sciences in Kansas City, MO., Western University in Pomona, CA., and Touro University in Vallejo, CA. Medical students will rotate through Sunnyside Community hospital to obtain clinical training in the following medical specialties: family, internal, surgery, pediatrics, and obstetrics/gynecology.

The economic condition of all health care facilities continues to be a concern**.** Rural hospitals and clinics are struggling to survive in the ever-changing realm of medical care. This was demonstrated in the Region by the June 2001 closure of the Level V designated trauma service in Cle Elum. Their closure leaves an unmet need for trauma services and creates long transport times from the upper Kittitas County area to the trauma service in Ellensburg.

B. Designated Trauma Services Goals

Goal: Trauma Services are designated at the recommended number and levels in the South Central Region.

Objective: During the biennium the Regional Council will continue to support the efforts of the trauma services that designated at lower levels to increase their designation levels, as they are able.

Strategy 1: In 2003-2004 work with the trauma coordinator and trauma physician leader at the Kittitas PHD#2 to identify what actions Regional Council can take to support the reopening of the level V designated trauma service in Cle Elum.

Strategy 2: Provide available Regional data analysis of population data, numbers of patients meeting trauma criteria, locations of health care facilities, existing EMS transport patterns and estimated EMS transport times to trauma services considering a higher level of designation

Strategy 3: Provide a Collector registry-training session for designated trauma centers in the region by June 30, 2004.

Projected Cost: While no hard regional data is available, some trauma services have estimated the cost for a Level III trauma service to upgrade to a Level II ranges from half a million to one million dollars. The cost for a Level IV trauma service to move to a Level III designation could be somewhat less. The greatest single cost for trauma services to increase designation levels is recruitment of specialty physicians, surgeons and other associated costs, including specialty equipment, staff training and staff salaries.

Barriers: The cost to increase designation levels is great.

C. Designated general, pediatric, and rehabilitation Trauma Services

As with EMS resources, the highest levels of trauma care resources are available in suburban/urban areas. Recommendations for levels of designation were based on resources, distances between health care facilities, and EMS transport times. Analysis from the survey of surgical and medical resources available at each facility, showed a broad spectrum of trauma care and medical staff capabilities, ranging from small rural clinics and hospitals with limited medical resources to large medical centers with sophisticated trauma care equipment and medical specialties. There are no recommended changes to the minimum or maximum recommendations for general, pediatric or rehabilitation trauma services.

Two Regional trauma services have used interesting approaches to the delivery of trauma care by using two creative designation configurations. Yakima Valley Trauma Service, a Level III designated trauma service in the City of Yakima, is a "joint" designation with Yakima Valley Memorial Hospital and Yakima Providence Medical Center. In the Tri Cities (Richland, Kennewick, Pasco) an even more creative Level III "tri designation" trauma service exists. Kadlec Medical Center in Richland, Kennewick General Hospital in Kennewick and Lourdes Medical Center in Pasco, share a designation with three campuses. This trauma system has a unique system of trauma call, utilizing designated telephones in each emergency department that allow for immediate communications among the three campuses. These designations are both a **strength,** with participation by all facilities, but a **weakness**, with lower than recommended levels of trauma designation.

General Trauma Services

Columbia County

The Regional Council first recommended one Level IV Designated Trauma Service in Columbia County, but due to lack of required anesthesia for surgical capabilities, a Level V trauma service is now recommended for Columbia County.

Actual Designation

Dayton General Hospital, in the town of **Dayton**, is a designated **Level V Trauma Service** with 28 beds and a two bed Emergency Room, staffed by RNs and on call physicians. Three general practice physicians practice at Dayton General. Dayton General is the only health care facility in Columbia County.

Kittitas County

Regional recommendation in the **City of Ellensburg,** is a **Level III Designated Trauma Service** and in the town of **Cle Elum,** a **Level V Designated Trauma Service**.

Actual Designation

Kittitas Valley Community Hospital, in the City of **Ellensburg,** is a designated **Level IV Trauma Service** with 50 beds and provides a full array of medical specialties with the exception of neurosurgery. (Regional recommendation is for a designated level III trauma service)

Kittitas County Public Hospital District #2 Emergency Room, in the town of **Cle Elum,** was a designated **Level V Trauma Service** with a four bed "free standing" Emergency

Room that closed due to economic and political issues in June 2001. The Regional Council continues to recommend a designated Level V trauma service in the Cle Elum area.

Benton and Franklin Counties

Regional recommendation in **Benton and Franklin Counties,** is one designated **Level II Trauma Service**, one designated **Level III Pediatric Trauma Service**, and one designated **Level II Trauma Rehabilitation Service** in the Tri Cities area (Richland, Kennewick, Pasco).

Actual Designation

Tri-Cities Trauma Service, located in Richland, Kennewick, and Pasco, is a *tri-designated* **Level III Trauma Service** with three campuses as follows:

Kadlec Medical Center, a 153-bed acute care facility, located in the **City of Richland,** provides a full range of medical and surgical services and specialties including neurosurgery and rehabilitation service.

Kennewick General Hospital, a 71 bed acute care facility, located in the **City of Kennewick,** provides full range of medical and surgical services and specialties including neurosurgery.

Lourdes Medical Center, a 135-bed acute care facility, located in the **City of Pasco,** provides a full range of medical and surgical services including neurosurgery. *Lourdes Medical Center* is a designated Level II Trauma Rehabilitation Service.

In the **City of Prosser,** *Prosser Memorial Hospital* is a designated **Level IV Trauma Service** with 21 beds. They provide a range of medical and surgical services including long-term care.

Walla Walla County

Regional recommendation in the **County** and the **City of Walla Walla,** is one designated **Level II Trauma Service**, one designated **Level III Pediatric Trauma Service**, and one designated **Level II Trauma Rehabilitation Service**.

Actual Designation:

St. Mary Medical Center, located in the City of **Walla Walla**, is a designated **Level II Trauma Service**, a designated **Level III Pediatric Trauma Service**, and a designated **Level II Trauma Rehabilitation Service** with 146 beds providing a full range of medical and surgical services and specialties including neurosurgery and rehabilitation services.

Walla Walla General Hospital, located in the **City of Walla Walla**, is a designated **Level III Trauma Service** with 72 beds providing a full range of medical and surgical services with the exception of neurosurgery.

Yakima County

Regional recommendation in **Yakima County,** is as follows: in the **City of Yakima**, one designated **Level II Trauma Service**, one designated **Level III Pediatric Trauma Service** and one **Level II Trauma Rehabilitation Service**; in the **City of Toppenish**, one designated **Level III Trauma Service**; and in the **City of Sunnyside**, one designated **Level III Trauma Service**.

Actual Designation:

Yakima Valley Trauma Service, in the City of **Yakima,** is a *joint designated* **Level III**

Trauma Service and a designated **Level III Pediatric Trauma Service** with campuses at Yakima Valley Memorial Hospital and Yakima Providence Medical Center. Yakima Providence Medical Center is a designated **Level II Trauma Rehabilitation Service**. Trauma service is provided on a daily rotation basis.

Yakima Valley Memorial Hospital has 226 beds, providing a full range of medical and surgical services including neurosurgery, pediatric and psychiatric services.

Yakima Providence Medical Center has 226 beds, providing a wide range of medical and surgical specialties including neurosurgery, cardio-thoracic surgery, and rehabilitation.

Providence Toppenish Hospital, located in the **City of Toppenish** on the Yakama Reservation**,** is a designated **Level IV Trauma Service** with 63 beds, providing a wide variety of medical services and specialties.

Sunnyside Community Hospital, located in the **City of Sunnyside,** is a designated **Level III Trauma Service** with 38 beds, providing a full array of surgical and medical services with the exception of neurosurgery.

Pediatric Trauma Services

WAC defines a "pediatric trauma patient" as a child known or estimated to be less than fifteen years of age. WAC provides designation for Levels I through III Pediatric Trauma designation. The Pediatric Trauma service designation has specific medical and surgical equipment and specialized pediatric care training requirement.

The Regional Council once again surveyed and evaluated specialized pediatric trauma and medical resources available through its Regional health care facilities. The conclusion of the analysis was that Regional pediatric trauma resources were consistent with Level III pediatric trauma service requirements.

The Regional Council then analyzed its large geographic area, pediatric trauma patient population, access to Level I and II Pediatric Trauma Services and pediatric trauma care resources available within the Region. The Regional Council recommended to DOH that three *Level III Pediatric Trauma Services* be designated in the same areas where Adult Level II Designated Trauma Services were recommended in the *City of Yakima, the City of Walla Walla, and the Tri Cities*.

Care of critical burns and critical pediatric patients are advanced medical and surgical resources not available within the Region. All Regional Trauma Services have interfacility transfer agreements and plans in place to transfer both critical burn patients and critical pediatric patients to Level I Trauma Services located in Seattle, Washington or Portland, Oregon.

Trauma Rehabilitation Services Resources

The State of Washington Trauma System is unique by including designated Trauma Rehabilitation Services. Washington's trauma system considers rehabilitation early in care of both adult and pediatric trauma patients. WAC 246-976 provides levels and requirements for designation of Trauma Rehabilitation Services. State designation of Trauma Rehabilitation Levels I and II follows the standards adapted from the Commission on Accreditation of Rehabilitation Facilities (CARF).

All designated Level II Trauma Rehabilitation Services are required to have trauma rehabilitation coordinators, who are responsible for trauma patient rehabilitation care from ED admission through discharge. All Level III Trauma Services are to have trauma rehabilitation resources available or have transfer agreements with designated trauma rehabilitation services.

When developing recommendations for minimum and maximum numbers and levels of designated trauma rehabilitation services, the Regional Council established a Rehabilitation Committee with representatives from health care facilities that provide trauma rehabilitation. A survey of trauma rehabilitation needs and resources was done and the results analyzed.

Keeping in mind that trauma rehabilitation involves patients, families, and even communities, the Regional Council asked DOH to designate a Level I Trauma Rehabilitation Service for the Eastern portion of the State. The South Central Region EMS & Trauma Care Council recommends *three Level II Trauma Rehabilitation Services in the City of Yakima, the Tri Cities (Richland, Kennewick, and Pasco), and the City of Walla Walla.* DOH did designate a Level I Trauma Rehabilitation Service in Spokane and also designated the three Level II Trauma Rehabilitation Services as recommended by the Regional Council. In addition to the designated trauma rehabilitation services, many health care facilities offer a variety of outpatient and home health rehabilitation services.

TABLE C

South Central REGION

FY 04/05 Regional Plan

Min/Max Numbers for Acute Trauma Services

LEVEL	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
II	3	3	1	3	3
III	3	3	4	3	3
IV	1	2	3	2	2
V	1	2	2	1	2
IIP	1	1	0	0	1
IIIP	2	3	2	3	3

Min/Max Numbers for Rehabilitation Trauma Services

LEVEL	STATE APPROVED	CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)

	MIN	MAX		MIN	MAX
II	3	3	3	3	3
III+			0		

+There are no restrictions on the number of Level III Rehab Services

Recommendations for minimum and maximum numbers and levels of designated trauma services, pediatric designated trauma services, and designated trauma rehabilitation services have been reviewed. The Regional Council recommendations have **not changed** since the first trauma Plan. However, due to the fact that two health care facilities not recommended by the Regional Council were designated and that other health care facilities have designated at levels lower than Regional Council recommendations, minimum and maximum trauma service numbers have become confused over the years. This Trauma Plan reflect the original and current recommendations for locations and levels of designated trauma services. The Regional Council continues to encourage trauma services to increase designation levels to the recommendations in this Trauma Plan.

VI. DATA COLLECTION AND SUBMISSION

The Regional Council is not clear what its responsibility is in the hospitals transition of inputting prehospital trauma data. The Region no longer has funds to support the Regional Data Coordinator position that at one time supplied technical support to EMS agencies and trauma services. The Regional Council and the regional CQI Committee continue to provide a Regional "First Responder Aid Service Short Report" form to encourage First Responder agencies to continue to submit data.

The Regional Council has long recognized that Trauma Registry data is crucial to future trauma system planning and implementation. Data provides information for evaluation of the evolving trauma system. WAC 246-976-430 directs that d*esignated* trauma services to collect trauma data for the state Trauma Registry.

For nine years, DOH encouraged collection of prehospital data with limited success. Currently, the statewide goal is for EMS to collect and submit prehospital data to the trauma services. The Trauma services then submit the EMS data. An identified weakness is that trauma services often are unable to obtain completed EMS run reports. Often first responder information is not passed along in the reporting process. A Regional need exists to determine the role of the Regional Council in the whole trauma service and prehospital data collection process.

Goal: Comprehensive regional Trauma Registry Data is available for system QI
Objective 1: Encourage and promote collection and submission of EMS and trauma service Trauma Registry data during the biennium.
Strategy 1: Encourage the prehospital agencies to submit the required data through the trauma services.
Strategy 2. Determine the role of the Regional Council in making prehospital data consistently available for trauma services to input into their Trauma Registries.
Projected Cost: Both the Trauma Services and the EMS agencies have stated that a part time to full time employee is needed to facilitate the submission of trauma registry data depending on the size of the trauma service or agency.
Barrier: Cost and reluctance by the EMS agencies to submit data.

VII. EMS AND TRAUMA SYSTEM EVALUATION

(Both prehospital and hospital components):

Effectiveness and Quality Assurance

WAC establishes and outlines the EMS and Trauma System Evaluation process (CQI Plan). The Regional CQI Plan was developed by the Level II and Level III trauma services. The CQI Plan identifies a continuum of timely analysis of trauma system trends coupled with actual trauma patient care issues. The regional CQI Committee, comprised of representatives from each of the Regional trauma services, prehospital providers, and EMS coordinators have established a regional CQI plan with the following goals:

Need: Timely information is needed for effective regional system CQI.
Goal: Timely regional system CQI results in timely data driven system improvement
Objective: Analyze trauma registry data and monitor trends in the Regional trauma care system quarterly.
Strategy 1: Regional CQI Committee meets three to four times a year and reviews trauma system outcomes including trends if available.
Strategy 2: The Regional CQI Committee will review pertinent trauma cases, review unexpected trauma patient survivals and deaths, review numbers and types of interfacility trauma transfers, and other issues related to the performance of the Regional trauma system.
Strategy 3. The Regional CQI committee will report aggregated system findings to the Regional Council for use in considering system changes within the South Central Region.
Projected Cost: Both the Trauma Services and the EMS agencies have stated that a part time to full time employee is needed to facilitate the submission of trauma registry data depending on the size of the trauma service or agency. The cost for an employee would vary greatly.
Barrier: Lack of participation by some trauma services, their medical directors and the local county MPDs.

Need: Confidential regional CQI issues and meetings
Goal: Regional CQI is a confidential and identifies opportunities for continually improving the regional system.
Objective 1: All members and guests read and sign a Confidentiality Agreement as outlined in RCW 70.168.090 (3 & 4) at each meeting.
Objective 2. Bimonthly reports to the regional council contain aggregate data.
Strategy: The Regional Council will continue to encourage the Trauma Services, EMS agencies and other trauma system partners to participate in the regional CQI system and programs.
Projected Cost: It is difficult to identify costs for CQI activities. Paying participants

would be prohibitive.
Barriers: Low interest and participation by Trauma Directors, MPDs, EMS agencies and Dispatch Centers.

Regional Council Representation - The South Central Region EMS & Trauma Care Council sends a representative who has been appointed to attend CQI Committee meeting. A CQI Committee report is provided at Regional Council meetings. As trauma system patient care trends and trauma system issues are identified, the regional CQI Committee will provide the Regional Council with statistics and information that will guide further revision and update of the Regional PCP's, trauma plan and trauma system.

Submitted by: _____ ***Date*** _____

Attachment 1 – South Central Region Patient Care Procedures

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURES #1	**Effective Date:** **07/24/96**	**Page:** **1 of 2**
Subject: **DISPATCH**		

I. STANDARD

1. Licensed aid and/or ambulance services shall be dispatched to all emergency medical incidents per the response maps developed by local EMS & Trauma Care Councils and the South Central Region.

2. Trauma verified aid and/or ambulance services shall be dispatched to all known injury incidents, as well as unknown injury incidents requiring an emergency response.

II. PURPOSE

To minimize "dispatch interval" and provide timely care by certified EMS personnel to all emergency medical and trauma patients.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. The nearest "appropriate" aid and/or ambulance service shall be dispatched per the above standards.

3. Trauma verified and licensed EMS services should proceed in an emergency response mode until they have been advised of non-emergent status.

IV. DEFINITION

1. **Appropriate** – Defined as the trauma verified or licensed EMS service that responds within an identified service area.

2. **Emergency Response** – Defined as a response using warning devices such as lights, sirens and use of Opticom devices where available.

3. **Dispatch Interval** – Defined as the time the call is received by the dispatcher to the time the first unit is dispatched.

V. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

I. STANDARD

All licensed and trauma verified aid and/or ambulance services shall respond to emergency medical and injury incidents in a timely manner in accordance with Washington Administrative Code (WAC).

II. PURPOSE

1. To provide "timely" emergency medical services to patients who have medical and/or injury incidents requiring emergency care response.

2. To collect data required by the state Trauma Registry and by the regional Continuous Quality Improvement (CQI) Plan.

III. PROCEDURES

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. Detailed maps of service areas are available through the South Central Regional office.

3. Trauma verified aid and/or ambulance services shall collect documentation for the Washington State Trauma Registry (WAC).

4. Included in the Trauma Registry information will be unit response time. Verified aid and/or ambulance services shall meet the minimum agency responses to response area as defined in WAC.

Trauma Verified <u>AID</u> Service

Urban	8 Minutes-80% of the time
Suburban	15 Minutes-80% of the time
Rural	45 Minutes-80% of the time
Wilderness	as soon as possible

Trauma Verified AMBULANCE Service

Urban	8 Minutes-80% of the time
Suburban	20 Minutes-80% of the time
Rural	45 Minutes-80% of the time
Wilderness	as soon as possible

IV. DEFINITIONS

1. **Urban** – Incorporated area over thirty thousand; or an incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square miles (WAC).

2. **Suburban** – Incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of less than 1,000 to 2,000 people per square mile (WAC).

3. **Rural** – Incorporated or unincorporated areas with totoal population less than 10,000 or with a population density of less than 1,000 per square mile (WAC).

2. **Wilderness** – Any rural area that is not accessible by public or private maintained roadways (WAC).

3. **Response Time** – Interval of time from agency notification to arrival on the scene. It is the combination of activation and in route times defined under response times (WAC).

4. **EMS Personnel** – First Responder skill level or higher

V. QUALITY ASSURANCE

The South Central Region CQI Committee, consisting of at least one member of the designated facilities medical staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional Standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #3	**Effective Date:** 07/24/96	**Page:** 1 of 4
Subject: TRIAGE AND TRANSPORT		

I. STANDARD

All licensed and trauma verified aid and/or ambulance services shall comply with the State of Washington Prehospital Trauma Triage Destination Tool as defined in Washington Administrative Code (WAC). Medical and injured patients who do not meet prehospital triage criteria will be transported to local facilities according to Regional Patient Care Procedures (PCPs), MPD protocols and County Operating Procedures (COPs).

II. PURPOSE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. To ensure that all trauma patients are transported to the most appropriate trauma designated facility in accordance with WAC.

3. To ensure that all patients that do not meet Trauma Triage Tool Criteria are transported according to COPs.

4. To allow the receiving facility or trauma designated service adequate time to activate their emergency medical and/or trauma response team.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may recommend local COPs or that meet or exceed the **STANDARD** and **PURPOSE** described above, and provide a copy to the Regional Council for adoption.

2. <u>Trauma Triage</u>

a. The first certified EMS provider to determine that a patient meets the trauma triage criteria, shall contact their base station, medical control, or the receiving trauma service via their local communication system, as soon as possible.

b. EMS Providers and their organizations shall transport patients in accordance with the Washington State Trauma Triage Destination Procedure, Regional Patient Care Procedures (PCPs), and COPs.

c. The Medical Control and/or receiving facility should be provided with the following information, as outlined in the Prehospital Trauma Triage Destination Procedure:

   1. Vital signs
   2. Level of Consciousness
   3. Anatomy of Injury
   4. Biomechanics of Injury
   5. Co-morbid Factors

d. Major trauma patient will be identified as the following:

   1. Patients meeting the first two steps of the current State of Washington Prehospital Trauma Triage Procedures published by DOH-EMS or any other DOH approved triage tool.
   2. Patients activating the Region's Trauma Services and hospitals in-house and full trauma team activation.
   3. Patients included by the Region's Prehospital services, designated trauma services, and hospitals in the State Trauma Registry using the Trauma Registry inclusion criteria as outlined in WAC.

e. If a patient meets the trauma triage criteria, a Washington State Trauma Registry Band should be attached to the patient's wrist/ankle.

f. Patients meeting trauma triage criteria are major trauma patients who may or may not have the ability to make an informed decision. They shall be transported to a designated trauma service in accordance with the State of Washington Prehospital Trauma Triage Destination Procedure or other DOH approved trauma triage destination procedure.

g. If prehospital personnel are unable to effectively manage a trauma patient's airway, an Advanced Life Support (ALS) rendezvous or an immediate stop at the nearest facility capable of immediate definitive airway management should be considered.

h. South Central Region Designated Trauma services and maps of their locations are available from the Regional Council Office.

i. Designated trauma services shall have written procedure and protocol for diversion of trauma patients when the facility is temporarily unable to care for trauma patients. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the decision to divert when stabilization in the closest emergency department might be life saving.

Note: Exceptions to diversion:

a. Airway compromise
b. Traumatic arrest
c. Active seizing
d. Persistent shock
e. Uncontrolled hemorrhage
f. Urgent need for IV access, chest tube, etc
g. Disaster

3. <u>Non-Trauma/Medical</u>

a. Prehospital personnel may request response or rendezvous with ALS/ILS providers and all EMS providers may request emergency aero-medical evacuation if they are unable to effectively manage a patient.

b. Medical and injured patients who do not meet prehospital triage criteria for trauma system activation will be transported to local facilities according to local MPD protocols and COPs.

c. While in route and prior to arrival at the receiving facility, the transporting agency should provide a complete report to the receiving hospital regarding the patient's status via radio or other approved communication system according to local MPD protocols and COPs.

4. Before leaving the receiving facility, the transporting agency will leave a completed MPD approved medical incident report (MIR) form or provide the information that entered the patient into the trauma system in the "receiving facility" approved method. The additional information from the MIR shall be made available to the receiving facility as soon as possible in accordance with WAC.

IV. DEFINITION

Designated Trauma Service – A health care facility or facilities in a joint venture, who have been formally determined capable of delivering a specific level of trauma care by the DOH.

QUALITY ASSURANCE

The South Central Region CQI Committee, consisting of at least one member of each designated facilities medical staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #4	**Effective Date:** 07/24/96	**Page:** 1 of 2
Subject: INTERFACILITY TRANSFER		

I. STANDARD

1. All interfacility trauma patient transfers via ground or air shall be provided by a trauma verified service with personnel and equipment to meet trauma patient needs.

2. Immediately upon determination that a patient needs exceed the scope of practice and/or protocols, EMS personnel shall advise the facility that they do not have the resources to do the transfer (WAC).

II. PURPOSE

Provide a procedure that will achieve the goal of transferring high-risk trauma and medical patients without adverse impact to clinical outcomes.

III. PROCEDURES

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. Medical responsibility during transport should be arranged at the time of the initial contact between receiving and referring physicians, and transfer orders should be written after consultation between them.

3. Prehospital protocols shall be followed during an EMS transport in the event that an emergency situation occurs while in route that is not anticipated prior to transport.

4. While in route, the transporting agency should communicate patient status and estimated time of arrival (ETA) to the receiving facility per local protocols and COPs.

IV. DEFINITIONS

Authorized Care – Patient care within the scope of approved level of EMS certification and /or specialized training as described in WAC.

V. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #5	**Effective Date:** 07/24/96	**Page:** 1 of 1
Subject: MEDICAL COMMAND AT SCENE		

I. STANDARD

The Incident Command System (ICS) shall be used.

II. PURPOSE

To define who is in medical command at the EMS scene and to define the line of command when multiple EMS agencies respond.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. Medical Command will be assigned by the Incident Commander.

3. Whenever possible, the Medical Commander/Medical Group Supervisor will be an individual trained in the ICS, familiar with both the local EMS resources and the county Mass Casualty Incident and Disaster Plan, and capable of coordinating the medical component of a multiple patient incident.

IV. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS and Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Regional CQI Committee will analyze data for patterns and trends and for compliance with Regional standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #6	**Effective Date:** 07/24/96	**Page:** 1 of 2
Subject: EMS/MEDICAL CONTROL COMMUNICATIONS		

I. STANDARD

Communications between Prehospital personnel, trauma services, and health care facilities will utilize the most effective communication means to expedite patient information exchange.

II. PURPOSE

To define methods of expedient communications between prehospital personnel and trauma services, other health care facilities, and medical control.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. The State of Washington (Office of EMS & Trauma) and the South Central Region EMS & Trauma Care Council will coordinate with the prehospital providers and trauma services, and other health care facilities, to develop the most effective communication system based on the EMS provider's geographic and resource capabilities.

3. Communication between EMS providers, trauma services, and health care facilities can be "direct" to trauma services or health care facilities or communications can be "indirect" from dispatching agency to trauma services or health care facilities.

4. County EMS/trauma councils will be responsible for establishing communication procedures between the EMS provider(s) and the trauma service(s) or health care facilities with input from the County Medical Program Director (MPD).

5. EMS agencies will maintain communication equipment and training needed to communicate in accordance with WAC.

a. Ground ambulance and aid services shall provide each licensed vehicle with communication equipment which:

1. Is in good working order.
2. Allows direct two-way communication between the vehicle and its system control point.
3. If cellular phones are used, there must also be a method for radio contact with dispatch and medical control.

b. In addition, prehospital services shall provide each licensed ambulance with communication equipment which:

1. Allows direct two-way communication, from both the driver's and patient's compartments, with all hospitals in the service area of the vehicle.
2. Incorporates appropriate encoding and selective signaling devices if appropriate.
3. When transporting patients out of normal service area, allows for communications with receiving facilities.

IV. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #7	**Effective Date:** 07/24/96	**Page:** 1 of 2
Subject: HELICOPTER ALERT AND RESPONSE		

I. STANDARD

Request emergency medical helicopter to the scene of a critical trauma patient as soon as possible.

II. PURPOSE

To define the criteria for request of on-scene emergency medical helicopter and who may initiate the request.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. On-scene emergency medical helicopter may be requested for patients in areas greater than 30 minutes ground ambulance transport time from a hospital who meet the first two steps of the Washington State Trauma Triage Tool or as directed by medical control.

3. The highest level EMS certified person on-scene should determine the need for on-scene emergency medical helicopter response, however on-scene law enforcement personnel may request emergency medical helicopter response when EMS personnel are not readily available.

4. Request for on-scene emergency medical helicopter should be initiated through the appropriate emergency dispatch agency. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units.

5. The emergency medical helicopter will transport the trauma patient to the highest designated level trauma service within 30 minutes air transport time from the scene.

6. The helicopter will make radio contact with the receiving trauma service as soon as possible.

IV. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional Standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #8	**Effective Date:** 07/24/96	**Page:** 1 of 2
Subject: DIVERSION		

I. STANDARD

All designated trauma services within the Region will have hospital approved policies to divert trauma patients to other designated trauma facilities.

II. PURPOSE

1. To divert trauma patients to other designated trauma facilities based on the facilities inability to provide initial resuscitation, diagnostic procedures, and operative intervention (WAC).

2. To identify communication procedures for diversion of trauma patients to another accepting facility.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. Each trauma service will have written policies and procedures that outline reasons to divert trauma from their service (WAC).

3. Trauma Services must consider diversion when essential services including but not limited to the following are <u>not</u> available:

    a. Surgeon
    b. OR
    c. For a Level II - CT
    d. For a Level II – Neuro Surgeon
    e. ER is unable to manage additional patients

4. When the trauma service is unable to manage major trauma, they will have an established procedure to notify the EMS transport agencies and other trauma services in their area that they are on trauma divert. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the

decision to divert when stabilization in the closest emergency department might be life saving.

Note: Exceptions to diversion:

a. Airway compromise
b. Traumatic arrest
c. Active seizing
d. Persistent shock
e. Uncontrolled hemorrhage
f. Urgent need for IV access, chest tube, etc
g. Disaster

5. Each designated trauma service will maintain a diversion log providing time, date and reason for diversion. This log will be made available to the regional CQI Committee for review if required.

IV. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #9	**Effective Date:** 05/22/97	**Page:** 1 of 2
Subject: BLS/ILS AMBULANCE RENDEZVOUS WITH ALS AMBULANCE		

I. STANDARD

In service areas with only BLS/ILS ambulances, a "rendezvous" with an ALS response will be "attempted" for all patients who may benefit from ALS intervention.

II. PURPOSE

To provide ALS intervention based on patient illness and or injury, and the proximity of the receiving facility in areas serviced by only BLS/ILS ambulances.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. Local EMS & Trauma Care Councils and MPDs that choose not to adopt their own protocol or policy shall adhere to the following procedures:
   a. Emergency Medical Dispatch Guidelines will be used to identify critically ill or injured patients.
   b. When an ALS response is deemed necessary or requested, the ALS service shall be dispatched with the BLS/ILS ambulance or as soon as possible.

3. The BLS/ILS ambulance may request ALS ambulance rendezvous at anytime.

4. Based on updated information, BLS/ILS personnel either while in route or on scene may determine that ALS intervention is not needed. The responding ALS ambulance may be notified and given the option to cancel.

5. Upon rendezvous, the method of transport, ie., BLS vehicle or ALS vehicle, shall be in the best interest of the patient's care in accordance with RCW 18.71.210.

IV. DEFINITION

1. **ALS** – Advanced Life Support as defined in WAC 246-976.010.

2. **Attempted** – After identification of the need for ALS intervention, every effort will be made to arrange a BLS/ILS ambulance with ALS ambulance rendezvous.

3. **BLS** – Basic Life Support as defined in WAC 246-976-010.

4. **Emergency Medical Dispatch Guidelines** – Established and accepted emergency medical dispatching guidelines that utilize specific questions and responses to determine EMS levels to be dispatched.

5. **ILS** – Intermediate Life Support as defined in WAC 246-976-010.

6. **Rendezvous** – A pre-arranged agreed upon meting either on scene, in route from or another specified location.

V. QUALITY IMPROVEMENT

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #10	**Effective Date:** 05/22/97	**Page:** 1 of 1
Subject: TRAUMA SYSTEM DATA COLLECTION		

I. STANDARD

Trauma verified EMS agencies and designated trauma services shall collect the required Trauma Registry data. Trauma Services will submit Trauma Registry Data to the Department of Health per WAC.

II. PURPOSE

1. To have a means to monitor and evaluate patient care and outcomes and the effectiveness of the EMS and Trauma Care delivery system.

2. EMS agencies will identify trauma patients using the parameters set by the Washington State Trauma Triage Tool or other DOH approved triage tool.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. EMS agencies will identify trauma patients using the parameters set by the Washington State Trauma Triage Tool or other DOH approved triage tool.

3. Designated trauma services will identify trauma patients using the Trauma Registry inclusion criteria.

IV. QUALITY IMPROVEMENT

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #11	**Effective Date**: **09/15/99**	**Page:** **1 of 2**
Subject: **ROUTINE EMS RESPONSE OUTSIDE OF RECOGNIZED SERVICE COVERAGE ZONE**		

I. STANDARD

Establish a continuum of patient care per the South Central Region EMS & Trauma Care Council's Trauma Plan.

II. PURPOSE

1. Provide an avenue for reliable EMS agency relationships and coordination of optimal trauma/medical patient care as described in the Regional Trauma Plan.

2. Provide for the safety of crews, patients, the public and other emergency responders.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. Local EMS & Trauma Care Councils will identify EMS agencies within the South Central Region and from other regions who routinely respond into areas beyond their recognized service coverage zone to provide ambulance service.

3. Local EMS & Trauma Care Councils will identify and encourage specific EMS Mutual Aid Agreements among EMS agencies that routinely respond into other service coverage zones that address the following:

   a. Dispatch Criteria
   b. Highest level of appropriate trauma verified EMS care utilized
   c. Transport to the appropriate designated trauma service or medical facility

4. Establish emergency response routes and notification standards.

    a. When enroute to a facility outside routine response area for the purpose of patient transfer, and when the response requires emergency response that crosses jurisdictional boundaries of counties, the base dispatch center may contact dispatch centers in those jurisdictions giving the route of travel, time of estimated arrival and destination.
    b. If transporting agency will be leaving the area in an emergency response mode, the procedure above may be followed.

IV. DEFINITION

1. **Routine** – Usual or established "response zone".

2. **Response Area** – A service coverage zone identified in an approved regional trauma plan.

3. **Emergency Response** – Defined as a response using warning devices such as lights and sirens and use of Opticom devices where available.

V. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #12	**Effective Date:** 09/15/99	**Page:** 1 of 2
Subject: EMERGENCY PREPAREDNESS/SPECIAL RESPONDERS		

I. STANDARD

Each county Emergency Management Administration within the South Central Region shall have a written Emergency Preparedness plan that includes EMS and health care facilities per RCW and WAC.

II. PURPOSE

To assure that the county Emergency Preparedness written plan addresses EMS and designated trauma services roles and responsibilities in multi-casualty and disaster incidents.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.

2. Local EMS & Trauma Care Councils will verify that EMS agencies and designated trauma services roles and responsibilities in county emergency preparedness plans are included and accurate.

3. Local EMS & Trauma Care Councils will verify and submit as an addendum a list of special responders from each county's emergency preparedness plans.

IV. DEFINITION

1. **Special Responders** – Organizations or individuals who provide and contribute emergency response and skills outside the usual and customary EMS response.

V. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.